ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE PACIFIC

SAVING OUR FUTURE:
Multiministerial Action Guide

HIV/AIDS in Asia and the Pacific

UNITED NATIONS

AusAID
The Australian Government's
Overseas Aid Program

Economic and Social Commission for Asia and the Pacific

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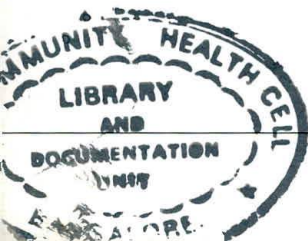The Australian Government's
Overseas Aid Program

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BOXES

AIDS	acquired immune-deficiency syndrome
ART	antiretroviral treatment
ARV	antiretroviral
CBOs	Community-based organizations
HAART	highly active antiretroviral therapy
HBC	home-based care
HIV	human immuno-deficiency virus
IDUs	injecting drug users
MSMs	men who have sex with men
NAC	National AIDS Committee
NGOs	non-governmental organizations
PHC	primary health care
PLWHAs	people living with HIV/AIDS
STIs	sexually transmitted infections
TB	tuberculosis

The preparation of this Action Guide drew from a variety of research and information sources both from within and outside of the Asian and Pacific region.

Below are the main sources used:

- The guide contains highlights from the theme study for the fifty-ninth annual Commission session. The theme study is entitled "Integrating economic and social concerns, especially HIV/AIDS, in meeting the needs of the region".

- The main analysis and recommendations for multiministerial action were adapted from the AIDS Toolkit prepared by Abt Associates Inc., together with the Health Economics and HIV/AIDS Research Division of the University of Natal, both of South Africa, and funded by the USAID Bureau for Africa, Office of Sustainable Development.

- Information on lessons from Africa were largely drawn from two sources:

    (a) A paper titled "The art of policy formulation: experiences from Africa in developing national HIV/AIDS policies" by John Stover and Alan Johnston, prepared for the Futures Group International's POLICY Project;

    (b) A paper titled "Lessons Africa has learnt in 15 years of responding to HIV/AIDS" presented at the African Development Forum 2000.

- Examples were also drawn from the Compendium of Reports, 2001, a publication based on the outcomes of the Asia-Pacific Ministerial Meeting on HIV/AIDS and Development in Melbourne, Australia, 9-10 October 2001.

Looking ahead into the future, identifying new challenges and providing strategies to overcome them is the primary task of any visionary leadership.

And today there is no challenge to the Asian and Pacific region's well-being that is more daunting than the HIV/AIDS pandemic. Given the devastating impact the pandemic has already had on the African continent and the rapid inroads it is making into our region – it is a threat that can be ignored only at our own peril.

While international bodies, civil society organizations and the private sector – all have an important role to play, it is governments in the region that are best placed to take initiative and tackle the pandemic in a comprehensive manner. With their popular political mandate, wide administrative reach and the ability to mobilize human and material resources governments have the advantage – and indeed the moral duty – to respond urgently to save the lives of their people.

The urgency of the tasks to be accomplished however, need to be well informed by good analysis and proper strategies. In the two decades since the HIV/AIDS pandemic was discovered, there is a wealth of experience from around the world in tackling it that can be put to good use in our region.

One of the most important policy lessons to have emerged from such international experience is that HIV/AIDS is a development challenge. This is particularly so in low and middle-income countries where the problems of under-development act as catalysts for the spread of HIV and exacerbate its impact on the population.

What such an understanding implies is that any response to the pandemic, has to be holistic in its approach – taking into account the social, economic and even cultural factors that play a role in both the

rise and fall of the pandemic. For governments in the region such an approach would mean involving all ministries – and not just the Ministry of Health – in the response to HIV/AIDS.

This Multiministerial Action Guide has been prepared precisely to emphasise the need for governments to take a holistic approach to the pandemic and suggest specific ways in which different ministries can be involved. It is an attempt to merge the best insights in tackling HIV/AIDS from around the globe with the specific needs and capabilities of the Asian and Pacific region.

The government agencies targeted in this Action Guide for analysis include the Office of the Head of Government/Head of State and the Ministries of Health, Finance, Education, Welfare, Labour and Agriculture. This is, however, by no means, a comprehensive list of the number of ministries that need to be involved.

Both the choice of these agencies and the suggestions made vis-à-vis their functions are meant only to illustrate the kind of assessments as well as action that will be required by every ministry in its response to HIV/AIDS. Due care has been taken to make suggestions that are generic in nature and relevant to as many countries in the region as possible. It is important to stress again that the best way to use this document is by adapting it creatively to local situations.

Given the diversity of governments and their internal structures in the Asian and Pacific region, the role of the same Ministry may vary from country to country. This Action Guide, in order to cater to the entire region, makes broad assumptions about the role assigned to various Ministries, that are in general accurate, but may not apply in some specific contexts.

The CD-ROM, "Bytes that matter", which accompanies the Action Guide provides useful background information on HIV/AIDS-related issues. It includes:

- An explanation of facts and myths about HIV/AIDS;
- A list of frequently asked questions (FAQs);
- A pathfinder on international HIV/AIDS mandates and commitments for policy action;
- A list of Internet information resources on HIV/AIDS;
- A glossary of HIV/AIDS terminology.

It is hoped that this Action Guide will be useful to officials, in government ministries throughout the region, to develop their own models of response to the HIV/AIDS pandemic. The Action Guide could also be a useful tool for civil society organizations, the private sector and international donors working with governments on HIV/AIDS issues.

HIV/AIDS: An overview of the Asian and Pacific situation

(a) Global context

The global HIV/AIDS pandemic, which started 2 decades ago, continues to spread to every corner of the world. It brings in its wake suffering and death to the individual household, disruption to entire societies and threatens the security and well-being of many nations.

The scale of the pandemic dramatically exceeds even the most pessimistic scenarios of a decade ago. At the end of 2002, there were 42 million people living with HIV/AIDS (PLWHAs) around the world. A startling 5 million people acquired the virus during 2002. Over 3 million people are estimated to have died of AIDS worldwide in 2002, including 610,000 children aged under 15.

(b) Regional dimension: cause for serious concern

The Asian and Pacific region threatens to displace sub-Saharan Africa as the new centre of the global HIV/AIDS pandemic over the next decade. With 62 per cent of the world's population and 19 per cent of the world's PLWHAs, the HIV/AIDS pandemic could reverse the social and economic gains made in the past half century in Asia and the Pacific — unless an expanded and comprehensive response is mounted across the region.

For Asian and Pacific Governments and leaders, several developments underscore the need for urgent action:

(i)   Currently, one in 5 new HIV infections worldwide occur in Asia and the Pacific.

(ii)   Globally, roughly half of all new infections are among young people. In the ESCAP region, over 8 million people were living with the virus at the end of 2002, of whom 2.6 million were young people aged 15 to 24.

(iii)   In 2002, AIDS claimed approximately half a million lives in the ESCAP region, while an estimated 1 million adults, children and youth were infected with HIV.

(iv)   The pandemic is growing at an alarming pace, including in parts of Central Asia, where HIV infection rates are rising steeply;

At present, the main mode of HIV transmission in the region is sexual intercourse, both heterosexual and homosexual. In many parts of the region, serious epidemics are also under way among injecting drug users. Other significant modes of transmission include the use of unclean needles and syringes, and unsafe blood and blood products.

Current country trends

Country trends in the ESCAP region may be separated into three categories.

In the first group are those ESCAP countries whose societies have reached serious HIV/AIDS levels, with adult HIV prevalence rates of over 1 per cent. It includes Cambodia (whose prevalence rate is over 2 per cent), Thailand, parts of India, parts of Myanmar and parts of Papua New Guinea.

The second group includes countries where the epidemic is still in a transitional stage, but where HIV prevalence is rising rapidly in specific populations and geographic areas. These include Armenia, China, Indonesia, Kazakhstan, Malaysia, Nepal, the Russian Federation, Uzbekistan and Viet Nam.

The third group includes countries and territories where extensive spread of HIV/AIDS is not evident: Bangladesh; Hong Kong, China; Islamic Republic of Iran; Lao People's Democratic Republic; Mongolia; Pakistan; the Philippines; Republic of Korea; Sri Lanka; Turkey and several small Pacific island countries and territories. In the case of the Pacific, limited information on HIV/AIDS spread is available. Nevertheless, conditions favour the rapid spread of HIV in many of these countries and territories.

However, macro-level trends do not always reveal the full picture. India (which has States in all three groups) and China illustrate how a low national HIV prevalence rate can hide serious localized epidemics. HIV epidemics always begin as geographically localized outbreaks and only later spread more widely across countries, territories and societies.

There is no guarantee that low prevalence rates will stay that way. Indonesia and Nepal, which are in the second group, are seeing a rapid rise in HIV infection rates, following years of consistently low rates. In Ho Chi Minh City, Viet Nam, HIV infection among sex workers increased from virtually nil in 1996 to over 20 per cent by 2000. In the Russian Federation, within 8 years, HIV/AIDS epidemics were discovered in over 30 cities and 86 of 89 regions. In that country, the total number of reported HIV infections climbed by over 1,800 per cent between the end of 1998, when the reported number was 10,993, to mid-2002, when the number was 200,000.

In conclusion, the global HIV/AIDS epidemic has yielded 3 inexorable facts.

- No country is immune from a serious HIV epidemic.

- Currently low HIV prevalence rates are no guarantee of low rates in the future.

- The current highest national infection levels in the region of 2 to 3 per cent of the general population do not represent a natural limit imposed by behavioural patterns
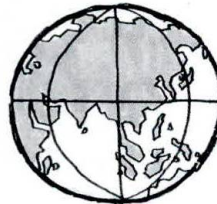
HIV/AIDS as a development challenge

Although HIV/AIDS is often presented as a purely medical problem, a closer analysis reveals it to be a much deeper development issue. It is no coincidence that, while highly developed countries have relatively low and stable HIV prevalence rates, many developing countries suffer from the highest prevalence levels.

Several broad development issues feature significantly in the spread of HIV in many parts of the world, including Asia and the Pacific. These include gender inequalities, illiteracy, population mobility, and lack of access to basic services, and opportunities for self-advancement. The paucity of information, especially among young people and other vulnerable groups (such as sex workers, injecting drug users, and migrant workers), is also one such factor.

In general, poorer countries of the world are home to the vast majority, some 95 per cent, of people living with HIV/AIDS. There are indications that high rates of extreme poverty (measured as income of less than US$ 1 a day) appear to be associated with HIV prevalence rates, as do poor rankings on the United Nations Development Programme (UNDP) Human Poverty Index. Poverty multiplies the pandemic's impact and, in turn, is itself exacerbated by the pandemic.

Household data from Cambodia and Viet Nam show strong correlations between levels of wealth, education and vulnerability, and HIV/AIDS. In Cambodia, which has one of the most advanced epidemics in the ESCAP region, the poorest segments of society have much less access to knowledge of how HIV is transmitted and prevented, are more likely to have sex at a younger age, use condoms less frequently and, in the case of young women, are more likely to turn to sex work as a means of supporting themselves and their families. Micro-level data from other parts of the Greater Mekong Subregion countries show that poverty drives many women into the sex industry, where their vulnerability to HIV infection dramatically worsens.
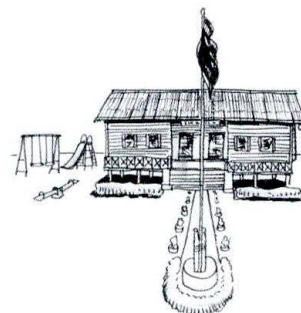
The impact of HIV/AIDS is unique because AIDS kills adults in the prime of their lives, thus depriving families, communities, and entire nations of their young and most productive people. Adding to an already heavy disease burden in poor countries, the HIV/AIDS epidemic is deepening and spreading poverty, reversing human development, worsening gender inequalities, eroding the capacity of governments to provide essential services, reducing labour productivity and hampering pro-poor growth.

The development approach to HIV/AIDS policy will require a shift in the very process through which policies are framed and interventions undertaken. The shifts in paradigm that will be required are outlined in the table below.

Box 1. The development approach to HIV/AIDS policy

From	To
Focus on partial, specialized knowledge of sectors.	Focus on holistic understanding of the entire system.
Health-centred: emphasis on sectoral goals.	People-centred and gender-sensitive: increasing, through empowerment and creation of enabling environments, people's prevention and coping capability.
Top-down development for the people.	Bottom-up development by the people, for the people.
Linear process.	Cyclical process.
Administrating, managing others.	Leading and empowering others.

Source: United Nations Country Team in Cambodia", Developmental implications of HIV/AIDS", (Phnom Penh, July, 2002).

The development process itself can inadvertently spur the spread of HIVAIDS. Widening inequalities (often associated with the earlier phases of development) can spur internal and cross-border migration, as people move in search of income and employment. Infrastructure development, especially of transport networks, urbanization, and rising disposable incomes, especially for men, many of whom spend periods away from their wives, are often associated with more extensive casual and multiple partner sexual activity and the growth of the sex industry.

Understanding the HIV/AIDS pandemic as a development challenge is crucial for formulating both long- and short-term policies to tackle the crisis at its roots. For example a development perspective implies the need for countries to improve overall, long-term social

and economic performance. At the same time, in terms of emergency measures for HIV/AIDS prevention and care-treatment-support, a development framework helps determine the process and approach required to make such measures effective.

The national response to the HIV/AIDS epidemic must include 3 dimensions:

(a) Measures to address its basic causes;

(b) Provision of preventive health care;

(c) Programmes for the care of PLWHAs, and mitigation of the impact of HIV/AIDS on PLWHAs and their families.

The national response should, therefore, include the following components:

(i) *Intensification* of *education, health, and food security efforts,* to achieve progress on the unfinished development agenda, including of poverty reduction strategies.

(ii) *Effective integration* of HIV/AIDS concerns into *national development planning, sectoral plans, and poverty reduction strategies,* as well as into *all Ministries* directly involved in the frontline of development, such as finance, health, education, rural development, agriculture, industry and transport, to accelerate the development process and tackle the HIV/AIDS epidemic.

(iii) *Support* for *greater social mobilization* efforts to accelerate the development process in general, and to tackle the spread of the epidemic in particular.

(iv) *Action* on the *economic empowerment* of women and *gender equality* as a national priority in the fight against HIV/AIDS.

(v) *Expansion* of *policy* and *public action* to provide a robust health delivery system that works for the prevention of HIV/AIDS and promotes *compassion* and *care* for PLWHAs, as well as to minimize stigma and discrimination against PLWHAs and their families.

Box 2. Lessons from Africa

In sub-Saharan Africa, the HIV/AIDS epidemic is taking a devastating toll in terms of human suffering. It is undermining economic growth, development prospects and political stability. Given the extent to which HIV/AIDS is eroding progress, it is no longer a medical health problem, but a major development crisis. While sub-Saharan Africa accounts for only one-tenth of the global population, it bears the brunt of the disease, with more than 80 per cent of AIDS-related deaths worldwide. Following is an excerpt from a paper titled **"Lessons Africa has learnt in 15 years of responding to HIV/AIDS"** *presented at the* **African Development Forum 2000.**

"AIDS is an epidemic with special features that call for a special response. With no vaccine available against HIV, prevention hinges on informing people, motivating them and empowering them to protect themselves, their partners and their new-born infants. Likewise, though the health sector is the mainstay of health-care for those infected, it can do little to alleviate the poverty that afflicts many AIDS-affected households, ease the plight of orphaned children, or safeguard a country's development achievements.

Instead, the response to HIV/AIDS demands strong and creative leadership from all sectors and parts of society, as much as increased community ownership of the problem and of its solution. Having analysed the impact of the epidemic, ministries of planning and finance must help ensure financing of crucial interventions for prevention and care – the two reinforce each other – and devise ways to alleviate the epidemic's toll on households, agriculture, mining and other sectors. Respected community leaders need to encourage people to take the invisible HIV threat seriously and, where necessary, change local attitudes and traditions that make people unnecessarily vulnerable to HIV or to the impact of AIDS.

Schools have a responsibility to inform children about HIV before they become sexually active and risk exposure, and teach them the skills they need to navigate safely through life. Religious leaders need to combat the blame and rejection associated with AIDS and encourage a "social contract" between the affected and the as-yet-unaffected. In places where the AIDS stigma is diminished, individuals living with HIV will feel freer to give the epidemic a human face and make their full contribution to combating it."

Source: http://www.uneca.org/adf2000/theme2contents.htm

HIV/AIDS and the role of governments

The Asian and Pacific region stands at a critical crossroads. A concerted and sustained response can hold the HIV/AIDS epidemic in check. Further delay in mounting effective prevention and care would see the region forfeit its opportunity to prevent the epidemic from spinning out of control.

Many governments in the region recognize the challenge and have begun to act. Those governments that have had some success in holding the epidemic at bay have publicly recognized the true nature and extent of the HIV/AIDS threat, committed sufficient resources, focused early efforts on the most vulnerable groups, and adapted their activities to new developments in the epidemic.

The pattern and course of the pandemic are known and predictable. This means that the epidemic yields to appropriate and sustained interventions. Examples of these include youth-focused prevention education, high levels of condom use among sex workers and their clients, and in casual sex settings and multiple sex partner relationships, as well as low levels of needle and syringe sharing, and use of safe blood and blood products. The spread of HIV/AIDS can be controlled.

Why early action?

Initially, the virus spreads mainly among vulnerable groups, such as injecting drug users, sex workers and their clients, and might remain so for several years. This tends to encourage the notion that the epidemic will stay confined mainly to those groups. In reality, none of the groups are sealed off from the rest of society. The epidemic eventually spreads among the wider population. Where circumstances favour the rapid spread of HIV, the consequences can be calamitous. The best course of action is early, comprehensive action.

In the early stages of the epidemic, comprehensive prevention among vulnerable groups is most cost-effective and could reduce new infections by over 60 per cent. The longer the delay, the lesser the payback in terms of infections prevented. For example, delaying by three years the introduction of a comprehensive prevention programme could mean that twice as many people would acquire the virus.

The types of approaches that boost results are also now better understood. Countries that have brought epidemics under control have cultivated wider acceptance of people living with HIV/AIDS, shown greater tolerance towards marginalized groups, effected large-scale improvements in access to treatment and care, and mounted prevention programmes that focus especially on vulnerable groups.

Cambodia and Thailand, for example, launched large-scale HIV/AIDS campaigns in the early stages of the epidemic, concentrating on the most vulnerable groups whose behaviour placed them at highest risk of infection. This enabled Cambodia and Thailand to reduce the spread of HIV and save millions of citizens from infection, illness and eventual death. Thailand could have had an estimated prevalence rate of 10 to 20 per cent and lost an additional 6 million lives, were it not for effective interventions launched early in the epidemic.

What works?

Societies are not powerless against the HIV/AIDS epidemic. The Asian and Pacific region provides some of the leading global examples of success against HIV/AIDS. Experiences worldwide confirm that the leadership of Prime Ministers and Presidents in directing national HIV/AIDS responses helps ensure that the responses are implemented as the highest national priorities. There is evidence of such leadership in the ESCAP region. For example:

- Since the early 1990s, Thai Prime Ministers have served as Chairpersons of the National AIDS Committee;

- The Prime Ministers of Cambodia, India, Indonesia, Malaysia and Papua New Guinea have personally endorsed national efforts to tackle the epidemic.

The multisectoral approach

Many countries in the region are adopting a multisectoral approach and are extending their HIV/AIDS responses across various ministries. Examples of this include the following:

- *Resource allocation and AIDS prevention, Thailand*: The 1996 AIDS budget of the Government of Thailand covered 91 per cent of all expenses in the country's AIDS programme. Creative prevention measures included life skills empowerment of young people, 100 per cent condom coverage of all sex service users, and strategic alliances with PLWHAs.

- *National coordination, Cambodia*: The national government set up a national body composed of 15 ministries, provincial governments, and the Cambodian Red Cross;

- *School AIDS education, Australia, Philippines and Myanmar*: Ministries of Education have included AIDS in the school curricula;

- *Protecting defence forces, Bangladesh, Lao People's Democratic Republic and Nepal*: Ministries of Defence conduct HIV prevention among uniformed service personnel;

- *Transport mode and mobile youth, China and Mongolia*: Ministries of Railways conduct AIDS education and HIV prevention among young migrant workers;

- *Infrastructure construction workers, Cambodia and Lao People's Democratic Republic:* HIV prevention among workers and surrounding communities is conducted in Sihanoukville International Port, Cambodia, and National Road No. 8, Lao People's Democratic Republic.

- *Mobilizing the media, India*: The Press Information Bureau helps sensitize the Indian media on HIV/AIDS issues.

Box 3. Bolstering multisectoral approaches

National coordinating bodies are also realizing the importance of bolstering the response through the workplace, and of including organizations with specific expertise in this area. Recently, India's National AIDS Control Organization (NACO) set up a technical resource group at the V.V. Giri National Labour Institute to develop research and training resources for workplace AIDS programmes. The Institute's partners in this effort include trade unions, employers' organizations, companies, NGOs undertaking HIV projects in the informal sector (notably with truck drivers and migrant workers), State or District AIDS Control Societies, and ILO.

Source: UNAIDS, *Report on the global HIV/AIDS epidemic* (Geneva, 2002), p. 111.

What can governments do?

The Asian and Pacific region holds the key to the future of the HIV/AIDS pandemic. Governments in the region face vital choices, if they are to control the epidemic and save millions of lives. Making those choices will require leadership marked by extraordinary vision and courage. Below are 5 sets of choices: *policy environment; resource generation and flow; institutional mechanisms; re-engineering government processes; and action on commitments*, that governments in the region could consider initiating in order to successfully stave off one of the gravest threats that the region faces today.

(1) Policy environment

(a) **Integrate HIV/AIDS issues into national development planning, sectoral plans, and poverty reduction strategies, for full mobilization of all sectors and levels of government:** Address the HIV/AIDS epidemic as a development issue, with education, health and nutrition, gender equality, and social justice dimensions, at the centre of a national HIV/AIDS response. Promote respect for the rights of PLWHAs and introduce anti-discrimination measures.

(b) **Focus on preventive and promotive health care, with special attention to HIV/AIDS:** Develop a wide spectrum of measures to prevent the spread of HIV infection among vulnerable groups. These include prevention fundamentals: focus on young people, achieve better understanding of the main modes of transmission, and acceptance of PLWHAs, promote condom use as a simple and effective prevention measure, and use of clean needles and syringes, and safe blood and blood products. Develop women-friendly measures that enable women to boost their autonomy and to take decisions that protect them from

HIV/AIDS. Assist in the development of HIV prevention vaccines that are best suited to Asian and Pacific conditions. Expand coverage of a comprehensive response to HIV/AIDS through improving the design and reach of current efforts, to increase the coverage of geographic areas and vulnerable groups.

(c) **Strengthen the integral link between prevention and care-treatment-support:** Include treatment and care for PLWHAs as an essential component of a national response to HIV/AIDS, whose long-term foundation is prevention. Provide vulnerable group-friendly services (condoms, clean needles and syringes, safe blood and blood products, sexually transmitted infection treatment), and foster conducive, user-friendly environments for accessing these services.

(d) **Guarantee equitable access to antiretroviral treatment and other HIV-related medicines:** Intensify action by governments and the pharmaceutical industry to increase the availability of affordable drugs. Initiate negotiations in appropriate forums to remove the patenting of ARVs from national legislation governing intellectual property rights. Exercise exemption from patent protection of ARVs, until 2016, in the case of least developed countries. Reform national legislation to achieve the lowest prices for quality pharmaceutical products, and to ensure that governments are able to use the flexibilities permitted under WTO agreements.

(2) Resource generation and flow

(a) **Ensure that adequate resources are available for implementing the national HIV/AIDS response:** Secure domestic resources for effective and sustained national responses that serve as building blocks of a region-wide response, with essential coverage of areas and vulnerable groups. Share country experiences on

international resource flows, such as from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, and other sources, and coordinate towards concerted regional responses to urge increased international resource allocations, that are in consonance with national priorities, to stop the spread of the pandemic in the Asian and Pacific region.
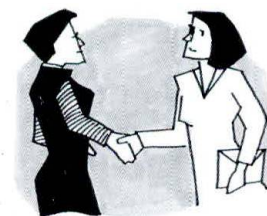
(b) **Mobilize the full potential of the corporate/private sector to operationalize the national HIV/AIDS response:** Create an enabling environment for the corporate/private sector to discharge its social responsibility and demonstrate good corporate citizenship by playing a larger role in the HIV/AIDS response, generating resources, implementing HIV/AIDS workplace programmes, supporting treatment and care for employees living with HIV/AIDS, and boosting care activities for children who become orphaned when their parents die of AIDS.

(c) **Make special provisions for the smooth flow of funds:** Enact regulations and adopt practices for speedy fund transfer and disbursement of HIV/AIDS resources to executing and implementing agencies, to expedite timely receipt and utilization. Establish, where necessary, new channels for expeditious fund transfer.

(3) Institutional Mechanisms

(a) **Locate the national focal point for HIV/AIDS in the Office of the Head of Government/State:** Accord the highest national priority to HIV/AIDS by locating the national HIV/AIDS focal point under the direct leadership of the Prime Minister or the President.

(b) **Constitute a national committee of ministers of relevant ministries, such as health, education, finance, planning, urban and rural development, agriculture, information and broad-**

casting, industry and transport, chaired by the Head of Government/State, to formulate a comprehensive national response to the epidemic, and with the powers to ensure its implementation: Guarantee resource availability, and optimize its utilization, by entrusting the key ministers for economic and social development with the responsibility of meeting the challenge of HIV/AIDS.

(c) **Decentralize implementation of the national response:** Design the national response to adequately meet local needs and priorities through delegation of authority and resources to implementing agencies and personnel at the local level.

(d) **Develop a wide network of agencies and organizations to implement the national response:** This could include government agencies, civil society groups, and the corporate/private sector.

(4) Re-engineering government process

(a) **Establish social auditing of HIV/AIDS programmes:** Identify institutions and organizations for conducting social audits of responses to HIV/AIDS issues, and entrust them with the responsibilities and resources for this. Guarantee that the social audits are participatory, with the active involvement of PLWHAs and community members. Make available the audit results in the public domain, to improve transparency and accountability.

(b) **Establish an effective monitoring and evaluation system:** Establish a credible system to monitor and evaluate the national response under the national committee of ministers (see 3[b] above). Foster a culture of taking prompt corrective action based on monitoring and evaluation.

> *"If you can mobilize resources for war, why can't you mobilize resources for life?"*
>
> Kofi Annan,
> Secretary-General, United Nations

(5) Action on commitments

(a) Implement commitments made in United Nations forums: Formulate an action plan for implementing international commitments made to tackle HIV/AIDS, including at UNGASS (2001), the Fifth Asian and Pacific Population Conference (2002), and at the fifty-seventh ESCAP Commission session (2001).

(b) Strengthen regional cooperation for tackling HIV/AIDS issues: This includes sharing knowledge and resources, as well as nurturing a common regional commitment to tackling the HIV/AIDS epidemic.

Box 4. The national programme in Cambodia

The national programme in 1997 conducted a situation and response analysis which brought together all the major stakeholders, from provincial AIDS offices to NGOs, bilateral donors, international organizations and the United Nations system. By that time the country was rated as one of the hardest-hit countries in the region. The team of reviewers set out a number of priority strategies and approaches based on the analysis undertaken. Among others, they recommended that the country base geographic and population priorities on the current epidemiological situation. Given the burden of HIV/AIDS they also recommended that provision of care and support be a priority cross-cutting strategy. With regard to sex work and STIs, major factors in the spread of HIV, specific priority activities were recommended to initiate and expand interventions among sex workers and their clients, promote condom use, especially in sex work settings, and improve the accessibility and quality of STI services. Another area for development and/or improvement was the capacity for voluntary testing and counseling. At the same time, the team emphasized the need for a response to match the dynamics of the epidemic, recommending that socio-behavioural and socio-economic research be strengthened so as to better inform programme design and guide policy.

Source: Peter R. Lamptey and Helene D. Gayle eds., *HIV/AIDS prevention and care in resource-constrained settings: A handbook for the design and management of programs* (Family Health International, Arlington, 2001) p. 16.

Four phases of policy development

Below is an extract from a report entitled **"The art of policy formulation: experiences from Africa in developing national HIV/ AIDS policies".** The report captures key elements of the HIV/ AIDS-related policy-making process in nine Anglophone African countries: Ethiopia, Ghana, Kenya, Malawi, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.[1]

There is a clear distinction between recognizing AIDS as a problem and determining the need for formal policies to tackle the disease. In most African countries, the first AIDS cases were reported in the mid-1980s. However, the development of comprehensive policies did not begin until the 1990s. Governments responded to the emerging problem with a variety of incremental steps before recognizing the need for a comprehensive policy. These responses can be summarized in 4 phases of policy development as described below.

The African experience

Phase I. Medical response: The initial response to AIDS in most countries was to treat the disease as a medical problem. Activities focused on screening donated blood, ensuring safe medical practices, and conducting surveillance and research. In most countries, the medical response coincided with the development of the first medium-term plan under the guidance of the Global Program on AIDS. The first cases of AIDS were identified, and while research showed that infection levels were increasing in some population

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[1] John Stover and Johnston, A, "The art of policy formulation: experiences from Africa in developing national HIV/AIDS policies" (*http://www.policy project.com/pubs/occasional/op-03.pdf,* August 1999).

groups, the number of AIDS deaths remained low. At this stage, medical and research guidelines were needed, but there was little recognition of the need for comprehensive national policies.

Phase II.   Public health response: As the epidemic progressed, governments and international organizations began to realize that a medical approach to HIV prevention and care was insufficient. Intervention research showed that progress toward prevention could be achieved with a combination of programmes, such as condom promotion, peer counselling, and mass media campaigns.   In this phase, the response to AIDS broadened considerably and, as a result, difficult policy issues began to arise, such as condom advertising in the mass media.   Governments generally dealt with these issues on an *ad hoc* basis through specific regulations or laws.

Phase III. Multisectoral response: At a later stage in the epidemic, the number of AIDS deaths began to rise. International organizations began to stress the broad social and economic impact of AIDS, spurring multisectoral responses. The involvement of all sectors of government in HIV prevention was encouraged. The role of the private sector, NGOs, and communities took on greater importance. By this time, the full range of difficult policy issues had become apparent, forcing governments to consider, for example, the situation of orphans, AIDS education in schools, the human rights of people living with HIV/AIDS, treatment and care, and research ethics. At this point, the need for a comprehensive national policy to address all of these issues became even more evident in most countries.

Phase IV.   Focused treatment and prevention: In many countries, the latest phase is distinguished by a focus on proven approaches. This may mean less emphasis on the multisectoral approach and greater emphasis on the most promising prevention interventions. The latest phase also includes a sharper focus on the ethical and resource issues associated with new treatment and prevention options, such as antiretroviral therapy and prevention of mother-to-child transmission.

Box 5. Information needs by stage of the policy process

Stage	Illustrative information needs
Problem identification	• Number of reported people living with AIDS by age, sex and region of country. • Surveillance information on HIV prevalence by vulnerable group. • Estimates of the number of infections.
Need recognition	• Projections of the future number of infections, people living with AIDS and deaths. • Estimates of the social and economic impact of AIDS. • Personal stories of the hardships caused by AIDS, illustrating impact on individuals, families and communities.
Advocacy	• Information showing the impact of AIDS on vulnerable groups and effectiveness of interventions.
Drafting and review	• Status and extent of epidemic. • Policy inventory of existing laws and regulations. • Model policies recommended by international organizations and conferences. • Examples of policies adopted by other countries.
Approval	• Views of interest groups on draft policies. • Estimates of the impact of policies on controlling the epidemic. • Estimates of the costs of policies.
Legislation	• Inventory of existing legislation. • Drafts of legislation required to address key policy issues.
Guidelines	• Scientific information concerning approaches that work and those that do not work.
Strategic planning	• Effectiveness of proposed interventions. • Cost-effectiveness and cost-benefit analyses. • Projections of resources required.

Source: John Stover and Johnston, A, "The art of policy formulation: experiences from Africa in developing national HIV/AIDS policies" (*http://www.policyproject.com/pubs/occasional/op-03.pdf,* August 1999).

Key actors in the policy process

There is a wide range of actors in the policy process. Each plays a distinct role. The degree of participation varies according to the stage of the process.

A. Key actors

Although all actors may be involved to some extent in all stages, they make their key contributions in only a few stages. In the case of HIV/AIDS, the groups include, but are not restricted to, the following:

1. **Technocrats:** epidemiologists, physicians, scientists, public health specialists, policy analysts, and economists in the Ministry of Health, national research institutions, and international organizations.

2. **Bureaucrats:** primarily from the Ministry of Health, Ministry of Planning, and the Office of the Prime Minister or the President.

3. **Special interest groups:** non-governmental organizations (NGOs) that provide HIV/AIDS prevention and care services, organizations of PLWHAs, community organizations, and organizations representing vulnerable groups, such as sex workers, travelling businesspersons and long-distance drivers.

4. **Politicians:** Ministers, Deputy Ministers, Members of Parliament, Cabinet Members, the President, and the Prime Minister.

5. **Donors:** representatives and staff members of key bilateral donors such as USAID, DFID, as well as the Danish, Japanese and Swedish development agencies, DANIDA, JICA and SIDA.

6. **United Nations and other intergovernmental organizations:** staff members of the United Nations system, including UNESCAP, and UNAIDS and its cosponsors (UNDP, UNESCO, UNICEF, UNFPA, UNODC, ILO, WHO and the World Bank).

B. Functions of key actors

1. **Problem identification:** is led by *technocrats* who collect and analyse data and present the analyses in various forms, and to different audience groups to illustrate HIV/AIDS trends, and current and future policy and programming scenarios. Information is often drawn from reported cases of people living with HIV/AIDS and surveillance studies for HIV infection.

2. **Need recognition:** comes from *politicians* who place AIDS on the policy agenda. Therefore, advocacy efforts are often focused on convincing politicians of the need for a comprehensive response.

3. **Advocacy for action:** can come from *any group*. Typically, interest groups and donors carry out advocacy. Advocates may forge alliances with *technocrats* and *bureaucrats* who see the need for accelerated policy action to advance their case through normal government channels. In some cases, far-sighted politicians recognize the need for more action and champion the development of comprehensive and effective responses.

4. **Information collection:** is conducted by *technocrats, academics, expert consultants* and also *PLWHA groups. Members of the United Nations system* could help gather examples of good practice and in facilitating study visits to examine lessons from programme implementation elsewhere.

5. **Drafting of policy documents:** is usually carried out by *bureaucrats*, with the participation of *other groups*. *Donors, members of the United Nations system* and other *international organizations* often play a role by presenting inter-country information to facilitate policy consideration of national experiences.

6. **Approval:** is usually a political process. In some countries the *Minister* of Health approves the AIDS strategy, although this is possible only with tacit approval from the Prime Minister or President. In most other countries, the Cabinet or Parliament approves the policy.

7. **Implementation:** can and should involve everyone. *Technocrats* need to provide information and remain involved in policy planning, review and strengthening. *Bureaucrats* create and run the formal structures that develop and implement policy. Interest groups advocate for action on specific portions of the policy. They also work through NGOs and other types of organizations representing civil society to implement some policy components and generate feedback for strengthening policy. *Politicians* need to be involved in developing the enabling legislation that may be required to implement some portions of the policy; they also allocate the funding for implementation. *Donors* often play a major role in funding and setting programme priorities.

8. **Review and feedback:** all groups have a role to play in helping to generate feedback on the efficacy of policy adopted, particularly its implementation dimensions. With the feedback provided, further efforts may be made to fill gaps and strengthen policy measures. In view of the urgency of early action in stopping the spread of the epidemic in Asian and Pacific countries, continuous feedback from diverse groups could be useful.

The need for a multiministerial response

Governments of the Asian and Pacific region today face a challenge for which few precedents exist. With every minute that ticks by, the HIV/AIDS pandemic makes inroads into the stability of societies, the foundations of development.

The need for adopting a multiministerial strategy stems from the fact that HIV/AIDS is a threat to social and economic development. Thus, only the full commitment of all ministries will suffice, to avert a human and development crisis.

The situation demands that vital choices be made. Making those choices requires that decision-making be marked by vision and courage. Special mechanisms, institutions, policies, resources and a new process are essential elements of an adequate response to the challenge that the pandemic poses to governments that are responsible for the lives of two-thirds of the world's population.

In order to achieve a comprehensive response that can turn the tide of the epidemic, government must reach most of its people in the shortest possible period of time and in a sustainable manner. This can be done through the work of diverse ministries and sectors that are already reaching vulnerable groups according to their respective development, social and business agendas.

Each ministry can motivate and facilitate the involvement of diverse development sectors that the ministry works with, according to its mandate, thereby ensuring that the national and subnational AIDS responses include sectors such as health, education, agriculture, commerce and transport.

For example, in its regular work, the Ministry of Education is already reaching young people and their teachers. Thus, it can integrate AIDS prevention into the education system. HIV prevention work also helps reduce the impact of AIDS on the education system.

A primary requirement for an expanded response is that government demonstrates a high level commitment to fighting HIV/AIDS through mutually reinforcing, multiministerial action set within the framework of a national AIDS strategic plan. Multiministerial involvement in a national AIDS programme and committee and integration of AIDS into a national development plan ensures that:

- A large pool of government resources is mobilized and shared;
- Ministerial activities are coordinated for sustained impact.

WHO should take the initiative?

Leaders wanted!

- Head of Government/Head of State;
- National AIDS Council/Committee;
- Civil society groups, people living with HIV/AIDS groups;
- International donors;
- Members of the United Nations system.

who?

WHAT needs to be done?

Below are a checklist of actions

A. First things first – take stock of the situation:

1. Develop a clear understanding of the following:

   - At what stage is the epidemic?
   - What is the current and potential impact of HIV/AIDS?
   - What steps have already been taken by government agencies, non-governmental organizations, other actors?
   - What resources are already available to tackle the problem?
   - What resources are likely to be mobilized?

2. To develop a successful multiministerial strategy to meet the HIV/AIDS epidemic, the following actions must be taken:

   - Assess *Ministry capacity* to anticipate the onslaught of the epidemic, and prepare for it accordingly.
   - Assess levels of HIV *awareness and knowledge* among workers in the respective sectors under the Ministry, and any productivity loss that might occur with a HIV/AIDS epidemic.
   - *Recruit* and *train* staff to deal with HIV/AIDS issues, including workforce morale and support provision, in areas of responsibility under the purview of the Ministry, as the epidemic hits.
   - *Monitor,* on an on-going basis, the impact of HIV/AIDS on the Ministry and its Departments, through internal and external assessments, to identify remedial responses within the remit of the Ministry.
   - Develop Ministry-specific *impact assessment* and responses that are synchronized with those of other ministries and departments.

For example:

- Is the HIV/AIDS epidemic still growing or has it stabilized?

- Are there important differences between the severity of the HIV/AIDS epidemic in different areas or among different population groups?

- Has a specific strategy for the Ministry's sectoral response to HIV/AIDS already been developed?

- Have cost-effective, sustainable approaches to prevention and HIV/AIDS care been identified or are further data or analyses needed to identify them?

- To what extent have other sectors recognized the need for multi-sectoral action and what is the role of the Ministry in mobilizing and supporting those sectors?

- What is the contribution of the private sector to HIV/AIDS prevention and care?

- To what extent are appropriate policies and treatment strategies already in place?

- Are there any indications of what extra resources might be available from the government, international donors or private sector for the response to HIV/AIDS?

B. Define priorities:

1. To prioritize areas of concern for a strategic plan, define the core functions of the Ministry. Assess the challenge of HIV/AIDS, guided by the following key questions for each ministry function and priority:

Key questions for ministry priorities:

(a) How does this function or service impact on the spread of HIV?

(b) How will the way HIV/AIDS impacts on wider society affect needs to be addressed by the Ministry and its function or services?

(c) What factors may increase or reduce ability to manage the impact of HIV/AIDS?

HOW to respond?

A. Establish a planning system:

1. Establish a system of multiministerial planning:

   - Composed of a national plan and sectoral plans for all central (federal) level ministries, and state or provincial plans, wherever applicable.

2. Observe, as a matter of policy and practice, the following essential principles of planning in the planning process:

   - *Pursue at all levels*, planning for action on HIV/AIDS issues.

   - Be *strategic, long term*, and deal with the factors that *trigger* the epidemic, as well as those that *fuel* its spread.

   - Provide a *participatory platform* for achieving a higher level of synergy among ministries, departments and sectors, in tackling the epidemic through a multiministerial approach.

   - Predicate the national strategic plan, as a matter of policy, on the participation of *all stakeholders*, including PLWHAs, groups with high-risk behaviours, and community representatives.

Box 6. A national STI programme in Lao People's Democratic Republic

Problem: In a 1995 survey of countries and areas of the Western Pacific Regional Office of the World Health Organization, only Lao People's Democratic Republic was identified as being without some form of a national STI programme.

Solution: An international donor undertook a situational assessment and, based on its findings, contracted with the Ministry of Health to develop a national programme.

Means:

- Strengthening the capability of the Ministry of Health to manage a national STI programme.
- Strengthening the public health care system to provide access to consistently acceptable, effective and affordable STI services.
- Establishing support mechanisms for planning, monitoring and supervising a national STI care and prevention programme.

Constraints:

- Support to the project is time-limited.
- Uncertainty over the ability of the Ministry of Health to finance consumables, materials and reagents, or service and replace equipment as necessary.
- Lack of funding for extension of the referral services to a wider area.

Results:

- A national central and peripheral STI programme structure is in place with appropriate support activities.
- Access to STI care is available at all levels of the health system in the pilot areas, and is being extended nationally through training.
- Access to acceptable STI referral services with aetiological case management in pilot areas

Expected Outcomes:

- Lower STI rates with improvement in the health of the community, particularly women and children.
- Reduced risk of HIV transmission.

Source: Peter R. Lamptey and Helene D. Gayle (eds.), 2001, *"HIV/AIDS Prevention and care in resource-constrained settings: A handbook for the design and management of programs"*, Family Health International, Arlington, p.399.

B. Decentralize implementation of the national response:

1. Ensure that the national response to HIV/AIDS is multilevel:

   - Fully utilize the multilevel reach of ministries, which are often in many locations, covering national to provincial and local levels.

   - Strengthen the national response to HIV/AIDS by bringing together an ensemble of constituent elements and pursuing the following actions:

     - Operationalize the response at different levels.

     - Expedite implementation of different aspects of the national response by the agencies that can best implement them.

     - Introduce sufficient flexibility and dynamism into the national response, to allow for community-, local- and provincial-level variations.

     - Ensure that, at the implementation stage, the national response adequately reflects local needs and priorities.

     - The national response must also be invested with administrative and financial flexibility, through delegation of authority and resources to implementing agencies

C. Facilitate a wide network to implement the national response.

The HIV/AIDS pandemic calls for highly diversified national responses. Government institutions, civil society groups, and the corporate sector, each with a comparative advantage and operating in diverse environments, can all contribute to efficient implementation of the national response.

   - Entrust to those agencies that have the greatest comparative advantage the implementation of the national response.

Office of Head of Government/Head of State

STEPS DESCRIBED IN THIS SECTION

WHY?

Introduces the role of the Office of Head of Government/
Head of State in tackling HIV/AIDS

WHO?

Identifies key actors for national responses

WHAT?

Contains a checklist of questions that identifies priorities

HOW?

Suggests appropriate action responses

For some countries, HIV/AIDS is already a national emergency. For others, if prevention efforts are not significantly scaled up and made more comprehensive, it could become a national emergency. Either way, there is no room for complacency in the Asian and Pacific region.

The location of the national focal point for HIV/AIDS is a key indicator of the degree of support that it has from the highest authority in the land and its scope for effective action. When the Head of Government/Head of State is the focal point, as is the case in all emergencies, a strong political message is conveyed that action on HIV/AIDS has full national backing.

Clear horizontal coordination across ministries can facilitate optimal resource deployment. This is possible only when the national focal point for HIV/AIDS is in the Office of the Head of Government/Head of State. Locating the national focal point in that Office signals to all ministries and government departments that HIV/AIDS ought to receive the highest consideration. Thus, it is extremely important to locate the national HIV/AIDS focal point under the direct leadership of the Prime Minister or the President.

The Office of the Head of Government/Head of State can be the nerve centre of the national response to HIV/AIDS by:

- Coordinating horizontally and vertically the multiministerial response;

- Monitoring regularly, on a monthly or quarterly basis, overall multiministerial performance, with close supervision of progress;

- Ensuring, where possible, that public information and advocacy create an environment conducive to stopping the spread of the epidemic;

- Facilitating partnerships among government, private sector and civil society;

- Mobilizing government and societal resources;

- Ensuring convergence of programmes initiated by various ministries.

WHO should take the initiative?

Leaders wanted !

- Head of Government/Head of State;

- Minister, Office of the Head of Government/Head of State;

- Focal point in the Office that coordinates with the National AIDS Committee and the Cabinet of Ministers.

who?

WHAT needs to be done?

WHAT?

Governments may consider some political, organizational, planning and budgetary mechanisms that provide the necessary incentives, and enable the multiministerial programme to be implemented and sustained.

Below is a checklist of questions that provide a guide to the type of assessment needed regarding the various functions of the Office of the Head of Government/Head of State.

Box 7. Data makes the difference

Public health officials need no convincing on the importance of dedicating time and resources to prevent the further spread of HIV. The same cannot always be said for policy makers in other sectors, who are confronted with pressing priorities of their own.

In the early phases of the epidemic, well-designed, credible behavioural data can warn of the possibility of rapid HIV spread and encourage policy makers to act to prevent that spread. But this can happen only if the data are presented in language that policy makers can understand, and in ways to which they can respond.

For example, a Ministry of Education may be interested in knowledge and attitudes among youth, while a Ministry of Manpower may want to know how widespread risk behaviour is in the urban adult population. The Finance Ministry may be startled by the implications of financing health-care if 10 per cent of those reporting risk behaviour were to become infected with HIV.

Demonstrating that behaviours do change following prevention activities – in groups with higher levels of risk behaviour and in the general population – is one of the most effective ways to increase support for prevention activities. Behavioural data showing changes over time should be presented simply and rapidly to policy makers who have the power to influence spending and programme direction.

Source: Peter R. Lamptey and Helene D. Gayle eds., *HIV/AIDS prevention and care in resource-constrained settings: A handbook for the design and management of programs* (Family Health International, Arlington 2001), p. 16.

(a) Political and organizational strategies:

1. Have all relevant ministries been included in the response to HIV/AIDS?

2. Is the ministerial involvement in the National AIDS Committee (NAC) at the highest levels?

3. Have HIV/AIDS capacities developed across all ministries?

4. Is the NAC secretariat effective in coordinating a multi-ministerial response?

5. Is there sufficient private sector and civil society participation in the NAC?

6. Has the NAC structure been decentralized and replicated at the provincial and district levels?

(b) Planning strategies:

1. Has a National AIDS Plan been developed for the country?

2. Have HIV/AIDS concerns been integrated into national economic and development planning?

3. Have HIV/AIDS concerns been integrated into impact assessments of major development projects?

(c) Budgetary strategies:

1. Are allocations of the HIV/AIDS budget to ministries proportionate to their mandates in national development, and priority areas in the National AIDS Plan?

2. Has the allocation of the HIV/AIDS budget been mainstreamed into the existing planning and budgeting process in each ministry ?

HOW to respond?

The responses suggested below include those aimed at assisting the Office of the Head of Government/Head of State to continue to achieve goals and fulfil its functions in the context of changing societal needs. It also shows how the Office could take action to reduce HIV spread.

(a) Political and organizational strategies:

1. Ensure that:
    - Sufficient political authority at national, provincial and local levels is exercised to drive multiministerial participation;
    - A coordinated and effective response is achieved through supportive organizational structures;
    - National and provincial strategies are based on a realistic situation assessment and response analysis.

2. Set up a National AIDS Committee (NAC) with a wide membership spanning all relevant government ministers.

3. Ensure high-level ministerial representation in the NAC.

4. Provide adequate resources to the NAC secretariat to enable effective coordination.

5. Ensure the participation of civil society and the private sector in the NAC.

6. Establish provincial and district AIDS Committees to decentralize action for a more effective national HIV/AIDS response and bring in the active participation of diverse departments and sectors.

7. Ensure a full response to the gender dimensions of the epidemic, through appropriate member selection and the inclusion of women's organizations in the NAC and local-level HIV/AIDS Committees. Implement an orientation programme on gender sensitivity and HIV/AIDS for all NAC members and NAC secretariat personnel. Use a checklist of gender-sensitive actions to enhance a gender-sensitive response to HIV/AIDS.

8. Include people living with, or affected by, HIV/AIDS in the NAC and in local-level HIV/AIDS Committees, to provide valuable insight into the nature of the epidemic.

(b) Planning strategies

1. Develop a National AIDS Plan under the aegis of the NAC and involving all relevant ministries.

2. Integrate HIV/AIDS concerns into the national social and economic development plan.

3. Ensure that HIV/AIDS issues are adequately reflected in poverty reduction strategies.

Box 8. Strategies

The fact that more and more Prime Ministers and Presidents, or their Deputies, are leading National AIDS Councils, Commissions, or similar bodies, reflects the increasing urgency with which these leaders view the threat posed by AIDS to national development. Such high-level leadership not only demonstrates political commitment, but it also encourages non-health ministries to develop activities to fight AIDS within their regular programmes.

However, caution is called for. Careful management of political mobilization and policy-making requires the avoidance of confusion among existing institutions that already implement AIDS-related activities.

Ministries of Health, for example, have traditionally taken the lead on AIDS programming, often through National AIDS Control Programmes. One way to avoid possible conflict is by setting clear responsibilities for coordination, advocacy and policy-making in a manner that does not undermine the mandate of Ministries of Health or of other existing structures.

In Kenya, for example, the National AIDS Control Council takes the lead on coordination and evaluation of all activities against AIDS, while the Ministry of Health manages the mainly health-related interventions. Large-scale assistance efforts, such as the World Bank's Multi-Country AIDS Program for Africa, have provided funds to both the National AIDS Control Council, to support coordination and to channel funds to non-health ministries and non-governmental actors, as well as to the Ministry of Health.

Source: UNAIDS, *Report on the global HIV/AIDS epidemic* (Geneva, 2002), pp. 176-177.

4. Ensure consistency between national and provincial priorities, while reflecting local dimensions of the epidemic, as appropriate.

5. Provide technical assistance to ministries as well as national- and local-level HIV/AIDS Committees to help develop their institutional capacities.

6. Include pre-approval/implementation impact assessments of major development projects in relation to HIV/AIDS

(c) Budgetary strategies:

1. Support an increase in the government budget for HIV/AIDS, to demonstrate collective commitment by all ministries.

2. Ensure that the AIDS budget request is mainstreamed into the regular budgeting process of each ministry to reinforce sustainable implementation.

3. Ensure that HIV/AIDS resources are distributed to ministries, on the basis of the National AIDS Plan, thereby encouraging participation in the national HIV/AIDS response.

4. Request the Ministry of Finance to develop effective systems that ensure that no bureaucratic delays occur in the disbursement of HIV/AIDS funds to ministries.

5. Set up and operate an independent mechanism for the audit and monitoring of resources deployed by ministries according to the National AIDS Plan.

Ministry of Health

STEPS DESCRIBED IN THIS SECTION

WHY?

Introduces the role of the Ministry of Health in tackling HIV/AIDS

WHO?

Identifies key actors for national responses

WHAT?

Contains a checklist of questions that identifies priorities

HOW?

Suggests appropriate action responses
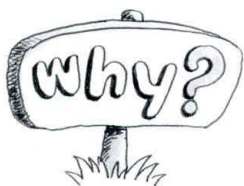
If allowed to spin out of control, the HIV/AIDS epidemic will reshape the demographic structures of societies in the form of increased morbidity, declining life expectancy and population loss. That, in turn, would affect birth rates, age structures and population growth rates.

Already, calculations made for four countries (Cambodia, India, Myanmar and Thailand) show that they could expect 2.2 million additional deaths due to HIV/AIDS in the period 2000-2005.

Adult death rates can be dramatically affected in the short term, since HIV/AIDS disproportionately strikes young adults. Estimates indicate that when the adult HIV prevalence rate reaches 4 per cent, HIV/AIDS could account for one-third of all adult deaths. No country in the ESCAP region has yet reached such a prevalence rate. However, badly affected areas in several countries of the region, for example, some provinces in northern Thailand, South-Central China and some States of India, could soon experience HIV prevalence rates of 4 per cent and higher, unless prevention efforts are further stepped up very soon.

The spectacular progress in child survival achieved in the region is also under threat. As the HIV/AIDS epidemic matures, mother-to-child transmission of HIV typically causes infant and under-5 mortality rates to rise. Some projections for Thailand, for example, warn that child mortality in 2010 could be 30 per cent higher as a result of AIDS.
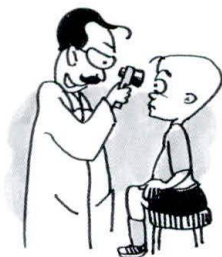
A growing epidemic slows — and eventually can even reverse —improvements in life expectancy. By the period 2010-2015, life expectancy in Cambodia is projected to be 59.2 years, that is, 5 years less than it would have been without HIV/AIDS.

HIV/AIDS is projected to reduce life expectancy at birth in Botswana and Zimbabwe by approximately 36.1 and 33.6 years, respectively, in 2000-2005. Based on the 45 countries for which such projections are available, a 1 per cent increase in the national adult HIV prevalence rate reduces life expectancy by approximately one year.

Impact on the health sector

The HIV/AIDS pandemic inflicts a high cost on the health-status of societies. It also has a multiplier effect on other prevalent diseases. By weakening and eventually destroying the immune system, HIV increases people's susceptibility to a variety of opportunistic infections, including active tuberculosis (TB). Indeed, people with TB who become infected with HIV face a 30- to 50-fold increase in their risk of developing active TB. It is estimated that most countries of the Asian and Pacific region could expect an increase of 5 to 10 per cent in HIV-related TB cases.

The HIV pandemic could have a dramatic impact on the capacity of health systems, with associated costs. In recent years, in the provincial hospital in Chiang Mai, northern Thailand, HIV-positive patients have occupied about half the beds. In 2002, Cambodia's health-care system had no additional capacity to provide appropriate treatment for the estimated 12,000 PLWHAs in need of care and support (communication received from the Secretary-General, National AIDS Authority, Cambodia, 22 February 2003).

HIV/AIDS poses occupational risks for health workers, who could acquire the virus (e.g., through needlestick injuries) or contract other opportunistic infections. It undermines morale in the absence of prophylactic treatment, as workload and stress levels increase, and as people experience the death of children, young adults and colleagues. Furthermore, the loss of health professionals to the pandemic may lead to a further deterioration of already strained health services in many countries in the region.
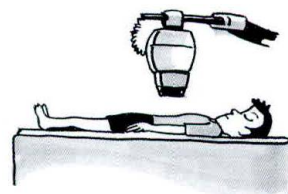
The Ministry of Health takes the lead in mobilizing the health sector and has a key role in the coordination of a multisectoral response, with the support of the Head of Government/Head of State. It has a central role in coordinating the national HIV/AIDS response within Government. It is also responsible, among others, for HIV/AIDS surveillance, prevention measures in health-care settings and providing care and treatment for PLWHAs.

WHO should take the initiative?

who?

Leaders wanted!

- Minister of Health;
- Secretary, Department of Health;
- Focal point in the Ministry that coordinates with the National AIDS Committee;
- Non-government and community groups involved in health-related work.

WHAT needs to be done?

WHAT?

Below is a checklist of questions that guide the type of assessment that needs to be carried out regarding the functions of the Ministry of Health:

(a) HIV prevention and health promotion

1. What are the needs for HIV prevention strategies, including education, especially among young people, empowerment of women, condom provision and STI treatment?

2. What should be targeted, in terms of vulnerable groups, practices and risk situations, to reduce HIV transmission most cost-effectively?

3. Is there a clear understanding, at all levels of the health system, of key requirements for successful HIV prevention programmes?

4. Which other Ministries and development sectors have major roles in HIV prevention?

5. What resources are available for HIV prevention programmes?

6. What are the bottlenecks and obstacles to effective HIV prevention programmes?

7. What are the needs for prophylaxis and secondary prevention of complications of HIV infection?

(b) Primary health-care (PHC) service provision

1. What levels of increased utilization of PHC services are being experienced and might be expected, with the spread of the epidemic?

2. What types of opportunistic infections and other HIV-related medical needs are presenting at PHC services or could potentially be managed effectively by PHC services?

3. What psychosocial needs would have to be met at the PHC level?

4. What is the current and expected impact of HIV/AIDS on number of tuberculosis cases (TB) in the population served?

5. What counselling and HIV testing needs to exist at the PHC level?

6. Does the TB control programme have the capacity to address a TB epidemic?

7. What diagnosis and treatment protocols are needed at primary facilities for common opportunistic diseases and conditions, and STIs?

8. Are PHC staff members adequately trained, experienced and supported to address medical and psychosocial needs that arise with the spread of HIV/AIDS?

9. Does HIV/AIDS create, at the PHC level, a need for certain new drugs, or more drugs, for example those for TB and STIs?

10. What needs for referral systems are created by HIV/AIDS that PHCs would likely have to address?

11. What extra facilities and personnel are needed to improve PHC accessibility for people living with HIV/AIDS, especially in poor communities?

12. What are the expected roles of current PHC staff in supporting home-based care?

13. Do they have the capacity to perform this role in addition to their other regular duties?
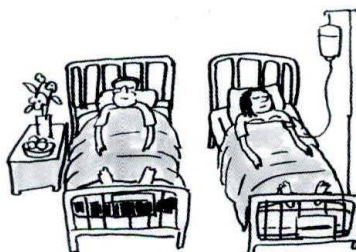
(c) Ensuring access to appropriate hospital care

1. What are the current levels of HIV/AIDS-related hospital utilization?

2. What is the projected number of people with HIV-related illnesses and AIDS?

3. How many of these are expected to seek hospital care and at what stage of their illnesses?

4. What are future bed needs likely to be? Data on the average number of admissions and average length of stay of people at different stages of HIV/AIDS may be used to obtain the estimates.

5. What would be the capacity of hospitals, according to current plans?

6. Have those plans considered projected HIV/AIDS needs?

7. What is the case mix of people currently hospitalized with HIV/AIDS-related illnesses?

8. What is the mortality rate among people admitted with various conditions?

9. What indications are there of trends in quality of care for people living with HIV/AIDS and other patients (e.g., mortality and admission rates)?

10. Which conditions have poor prognoses and may be most appropriately treated with palliative care?

11. Which conditions can potentially be cared for in other settings, e.g., home-based care?

12. What are the needs for chronic TB in-patient care, due to social circumstances and multi-drug resistance?

13. What types of staff members are most cost-effective and feasible to train on the scale required to meet HIV/AIDS-related needs?

14. What inefficiencies (e.g., extended length of stay, low occupancy of some wards) may waste capacity to meet needs?

15. What guidelines and systems for clinical care, admission, discharge and referral are in place?

16. Do they fit in with overall strategy on hospital care?

(d) Home-based and other non-hospital care strategies

1. What are the priority medical and other needs of people in an advanced stage of AIDS?

2. What models of home-based or other terminal care may help meet the needs of people in an advanced stage of AIDS?

3. What are the current and projected numbers of patients who are candidates for each type of care, in view of their social, economic and other circumstances?

4. What are the financial and other costs, to the health service and to households, of various models of care?

5. What is the impact of HIV/AIDS on the workload of staff members involved in various care strategies?

6. What training and support do caregivers and health care staff members need, to enable them to provide the requisite care for people living with HIV/AIDS?

7. What financial and staff capacity are, and would be, available for these services?

8. Are referral systems to and from home-based care (HBC) and other care points able to cope with the workload efficiently?

9. Are care strategies, such as HBC, strengthened by good coordination with NGOs, community-based organizations (CBOs) or initiatives by Ministries of Welfare and Education, for example, to create a continuum of care for people living with HIV/AIDS, orphans and other dependants?

(e) Blood supply

1. Is a regular supply of safe blood assured?

2. What are the extra costs of assuring a safe blood supply, e.g., from testing, and discarding of infected blood?

(f) Stress and burnout among health-care personnel

1. Is HIV/AIDS causing burnout and stress among health care personnel, due to factors such as increased workload, high mortality among young patients and illness of colleagues?

2. Has stress, such as that related to workplace exposure to HIV or exposure of infected staff to opportunistic infections, been addressed?

3. Has stress on all concerned staff members, including dieticians, oral health and laboratory staff, been considered?

(g) Public-private partnership

1. To what extent is the private sector likely to be significantly impacted by HIV/AIDS costs?

2. What are the consequences, if the private health sector prevention and care response is not efficient and equitable?
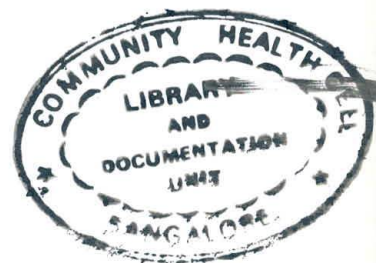
3. Is the private health care sector mobilized to respond to HIV/AIDS in a cost-effective, sustainable and equitable way?

4. Are strategies and mechanisms in place to ensure effective and sustainable involvement of CBOs and NGOs in prevention and care?

5. Are traditional healers contributing to effective HIV/AIDS prevention and care?

(h) Leadership and coordination

1. Is the Ministry of Health (MoH) providing the necessary leadership and support for intersectoral HIV/AIDS responses?

2. Are people living with HIV/AIDS adequately involved in prioritizing the use of available resources?

3. To what extent are planners and managers of hospitals, PHC and other health system components involved in adequate mobilization and coordination around HIV/AIDS?

4. Are other sectors mobilized and committed to addressing HIV/AIDS issues?

5. Are health information and other MoH systems giving adequate information and technical inputs to guide health- and intersectoral initiatives, e.g.:

    • Statistics on the epidemic and its impact?

    • Economic evaluations?

    • Counselling standards?

    • Condom quality assurance?

    • Post-exposure prophylaxis policies?

6. Are demands for inputs into the inter-sectoral response leading to adequate focus and capacity for effective health sector strategy development and implementation?

(i) Policy and legislation

- Do any current or planned policies and legislation related to the sector:

    1. Increase or decrease the rate of spread of HIV infection?

    2. Actively reduce stigma and discrimination against people living with HIV/AIDS or people affected by it, to encourage disclosure to strengthen prevention and impact management?

    3. Need adaptation to meet new challenges to implementation because of HIV/AIDS? For example, strengthening staff capacity to meet HIV/AIDS care needs may require change to staffing norms and job descriptions, to facilitate more rapid and cost-effective training and employment.

HOW to respond?

The responses suggested show how the Ministry can take action to reduce the spread of HIV.

Some responses may actively address impact. Others may include more detailed research on, and planning of, specific issues. It is important to prioritize responses that are most critical and feasible in specific situations. The appropriate participation of key stakeholders is likely to be important for effective prioritization and buy-in.

(a) Prevention and health promotion

1. Evaluate and refine existing prevention programmes.

2. Use innovative routes and messages so that HIV/AIDS informa-tion and education continuously have credibility and maintain a high profile. For example, radio and TV drama, agricultural extension officers and popular personalities have been used. So too have schools, post-offices, temples, mosques and churches.

3. Develop plans to provide for health promotion items such as budgets, staff, training and drug supplies.

4. Ensure that programmes go beyond education and information, and actually empower people to change their behaviour for HIV prevention.

5. Develop specific strategies to target vulnerable groups, as well as high-risk behaviours and situations.

6. Strengthen skills, understanding and support materials for health personnel to participate fully in HIV prevention activities.

7. Ensure adequate systems for reliable, easy access to free or subsidized condoms.

8. Set standards for condom distribution and use and monitor condom quality.

9. Mobilize other sectors to ensure effective roles in HIV preven-tion.

10. Ensure that STI services are user-friendly, can be accessed by those who need them, and are effective.

11. Investigate and implement effective and appropriate use of prophylaxis and secondary prevention.

(b) Ensuring access to primary health care (PHC)

1. Ensure that PHC services are effective in playing a key role in HIV/AIDS responses, especially by being more accessible to local communities, and in preventing and treating illnesses before they become so serious as to require hospital care.

2. Identify and monitor the impact of HIV/AIDS on PHC services.

3. Clarify realistic strategic and operational roles of PHC services in HIV/AIDS care, to reduce reliance on hospital care.

4. Ensure that PHC planners and staff members understand, and are committed to, their role in the HIV/AIDS response.

5. Ensure that all PHC services provide effective, accessible STI services.

6. Prioritize the effectiveness of TB services and programmes.

7. Develop PHC guidelines for diagnosis and treatment of HIV/AIDS-related conditions, and evaluate their implementation.

8. Train PHC staff members, as necessary, in effective diagnosis and treatment of TB, STIs and other HIV/AIDS-related conditions, and ensure follow-up support and monitoring.

9. Review, streamline and monitor referral systems.

10. Develop counselling and support skills and the capability of PHC service providers to meet psychosocial needs arising from the spread of HIV/AIDS.

11. Develop a voluntary counselling and testing strategy and systems.

12. Ensure the commitment of other sectors, e.g., welfare, and proper coordination, to provide support for people living with HIV/AIDS and their households.

13. Invest in facilities and personnel, as necessary, to ensure equitable and accessible PHC services for people living with HIV/AIDS.

14. Review PHC service staffing to ensure adequate capacity.

(c) Ensuring access to appropriate hospital care

1. Identify and monitor HIV/AIDS impact on hospitals.

2. Ensure that hospital planners, managers and staff members recognize the need to develop strategic plans to manage HIV/AIDS care needs.

3. Develop efficient coordination mechanisms with planners, managers and staff members of PHC, welfare and community-based care.

4. Define guidelines for a "core package" of hospital care, to be provided to people living with HIV/ AIDS and terminal illnesses.

5. Develop guidelines for clinical management, admission, discharge, and referral to and from other services, in line with the strategic plan.

6. Develop counselling capacity in hospitals, to facilitate more efficient testing and care planning with clients and caregivers.

7. Develop capacity to undertake viral load testing and monitoring, or to facilitate convenient access to that service.

8. Address key bottlenecks and inefficiencies related to hospital staffing, care processes and capacity use.

9. Ensure timely expansion of hospital capacity based on projected needs, options for care, costs and available resources.

Box 9. Health-care – just 75 cents away!

At a time when most governments around the world are privatizing their public health-care systems and cutting back on expenditure, Thailand is showing that state-sponsored universal health-care is still possible.

Since February 2001, Thailand has been experimenting with a novel national health programme that provides medical services, including surgery, to Thai citizens at just Baht 30 (equivalent to US$0.75) per visit to a hospital. Patients from low-income families do not have to pay anything.

The programme builds on Thailand's various health insurance schemes, which by 1998, covered up to 80.3 per cent of the country's over 60 million people. The remaining people who have been given insurance cover now are typically among the poorest in society. They include slum dwellers, subsistence farmers, rural workers and the very low-income self-employed.

Under the new system, the Government compensates health care service providers according to the number of registered patients they have. In addition to an allowance of Baht 1,200 (equivalent to US$30) per patient, resource-strapped hospitals can draw on a US$122 million contingency fund and claim fees for referral patients.

At present, the service package includes most health services except cosmetic care, obstetric delivery beyond two pregnancies, drug addiction treatment, haemodialysis, organ transplant, infertility treatment and other high-cost interventions. Initially, Thailand's thousands of people living with HIV/AIDS were only eligible for treatment of opportunistic infections. Following pressure from PLWHA groups, there are now plans to include more expensive ARV treatment in a step-by-step process.

There has been criticism about aspects of the Baht 30 health scheme. Most notably, the criticism points to the poor quality of medical services provided in rural areas and the consequent pressure on better-equipped urban hospitals when they are flooded with out-of-town patients.

Although the Thai experiment is still in its early stages, its importance lies in the following:

(a)   The political commitment shown by the Government of Thailand to bring public health to the top of the national agenda;

(b)   Investing significant funds into universal health-care, even though Thailand is just recovering from a severe economic downturn;

(c)   Evolving a viable model for other middle-income countries on how to deal with unequal access to health-care and its impact on poverty.

Source: Adapted from Nutta Sreshthaputra, "The Universal Coverage Policy of Thailand: An Introduction", paper prepared for the Asia-Pacific Health Economics Network (2001).

(d) Implementing home-based and other non-hospital care

1. Clarify types and scale of needs to be met, different models of care, cost and capacity issues.

2. Pilot and evaluate various models of care.

3. Ensure efficient systems for referral and for support of health care service staff involved in home- based or other forms of care.

4. Ensure adequate numbers and skills of staff to provide information, training and support to caregivers.

5. Develop protocols and systems to provide information and basic training to caregivers, before people living with AIDS are discharged from hospitals.

6. Ensure the availability of a key package of medical supplies for home-based and other types of care.

7. Develop quality assurance mechanisms for each type of care.

8. Develop policies and mechanisms to support effective and sustainable roles for non-governmental and community-based organizations involved in care and support.

9. Ensure that Ministries of Welfare and Social Development reinforce community and household capacity to cope with care and non-medical needs.

(e) Blood supply

- Develop or refine systems to ensure safe blood supplies and manage the costs of ensuring such supplies.

(f) Stress and burnout among health care personnel

1. Ensure effective policy, guidelines and implementation for precautions to reduce occupational exposure to HIV, and exposure of workers living with HIV/AIDS to opportunistic infections, especially TB.

2. Encourage open discussion of staff concerns, make counselling available and support staff involved in counselling.

(g) Public-private partnership

1. Develop a strategy and mechanisms to ensure sustainable and cost-effective private sector HIV/AIDS prevention and care.

2. Ensure effective private sector roles in addressing key public health problems, such as HIV prevention, STIs and TB.

3. Monitor delivery by industry clinics and other private sector health service providers, to ensure adequate standards of care.

4. Develop strategies and mechanisms to ensure effective and sustainable involvement of CBOs and NGOs in prevention and care, e.g., home-based care and counselling.

5. Develop a strategy to involve qualified and reputable traditional healers in prevention and support.

6. Provide a conducive policy and regulatory environment for an effective private sector response to HIV/AIDS.

(h) Leadership and coordination

1. Ensure adequate technical support, and quality data from health information systems and other sources, to guide HIV/AIDS planning in health and other development sectors.

2. Ensure that people with HIV/AIDS have a strong role in defining priorities for use of available resources.

3. Ensure coordination of HIV/AIDS-related planning and operations among all relevant components of health services and HIV/AIDS programmes.

4. Mobilize other sectors to respond to needs for HIV prevention, and care and support.

5. Develop programmes to reduce stigmatization and discrimination of people living with HIV/AIDS, to facilitate more effective prevention and care.

Box 10. HIV/AIDS situation assessment in China

In 1997, the Ministry of Health, China, carried out an HIV/AIDS situation assessment with support from the United Nations system and other national and international partners to map out the priorities and needs for an effective response to the problem. The result was a national-level, medium- to long-term plan that set out broad national objectives and strategies. These have to be reflected in specific provincial and local government policies and strategies according to their respective situations. Given the size of China, these situations are as different as they are complex and there has to be a strategic approach to planning at the local level. The United Nations system and other agencies are collaborating with a core working group on strategic planning at the central level and with local authorities to address these diverse and specific situations. A pilot situation and response analysis was conducted in one province, Guangxi, at the provincial as well as the more decentralized prefectural and county levels. These served to guide similar processes in other provinces in 2000. In this way China is implementing its policy of planning its HIV/AIDS prevention and care activities to match the diverse and changing determinants in provinces, counties and municipalities.

Source: Adapted from Peter R. Lamptey and Helene D. Gayle eds., _HIV/AIDS prevention and care in resource-constrained settings: A handbook for the design and management of programs_ (Family Health International, Arlington, 2001) p. 16.

Ministry of Finance

STEPS DESCRIBED IN THIS SECTION

WHY?

Introduces the role of the Ministry of Finance in tackling HIV/AIDS

WHO?

Identifies key actors for national responses

WHAT?

Contains a checklist of questions that identifies priorities

HOW?

Suggests appropriate action responses

Projections for the Asian and Pacific region suggest that billions of dollars and millions of lives could still be saved in this decade, if Governments were to invest urgently in prevention measures. In a 2010 "costs-of-inaction" scenario, young, productive citizens would be lost to the pandemic, business profits would slump, household income and standards of living would plummet, and economies would stagnate.

In the worst-affected countries of the world, HIV/AIDS is reversing annual economic growth rates by as much as one to two percentage points. In some countries, if the epidemic were to remain unchecked, economic wealth could decline substantially by 2020. National studies of two African countries with adult HIV prevalence rates higher than 30 per cent indicate that their economies would grow by 2.5 and 1.1 percentage points less by 2015, respectively, than they would have in the absence of AIDS. Higher morbidity and mortality levels also drain national economies by reducing the volume of available savings and changing the way in which savings are used. Ultimately, this too affects economic growth.

Meeting the challenge of the HIV/AIDS pandemic is a long haul and necessitates sustained investments. These investments have to be in all development-related sectors, including elementary education, health-care, social justice, and even defence and security.

The Ministry of Finance, as the fulcrum of the financial system, exercises considerable power to raise resources and to influence resource deployment, across ministries and sectors of the economy. The ministry also has the power to provide fiscal incentives through various subsidies.

When it comes to meeting the challenge of the HIV/AIDS epidemic, the ministry's functions are pivotal and equipped for grappling with issues such as the following:

- Allocating funds to mitigate poverty as a result of the epidemic;
- Allocating funds for expanding HIV prevention;
- Meeting home-based care needs of persons living with AIDS;
- Addressing increased demands for health care services.

It is, therefore, imperative that the Ministry of Finance has a clear understanding of what data and information are required from different ministries and development sectors, to determine the overall cost of meeting the HIV/AIDS challenge.

WHO should take the initiative?

- Minister of Finance;
- Secretary (Expenditure), Department of Finance;
- Focal point in Ministry of Finance that coordinates with the National AIDS Committee;
- Business leaders, and representatives of employees' associations.

WHAT needs to be done?

The Ministry of Finance decides on the allocation of budgets to the various ministries and development sectors. It is therefore imperative that this ministry considers what information it requires from those ministries and sectors in order to decide on overall allocation, as well as specific funds to mitigate the impact of HIV/AIDS impact and prevent new infections. In this regard, critical questions need to be posed.

Some external impact may already be experienced, but many would be fully felt only in the medium- to long-term. The type of impact assessment and responses to be decided on would depend on the particular stage of the epidemic and the extent to which resources have already been mobilized to address HIV/AIDS.

Key areas under the Ministry of Finance that would need rethinking in order to tackle the HIV/AIDS epidemic include the following:

- Macroeconomic policy and priorities;
- Policy and legislation.

Below are examples of the type of assessment that needs to be done with respect to both these areas:

(a) Macroeconomic policy and priorities

1. What are the overall resources available for government spending and how much flexibility is there likely to be, to meet new needs as a result of HIV/AIDS?

2. What are the current mechanisms for determining the allocation of funds among sectors or sectoral clusters, and how much flexibility is there likely to be to respond to new needs?

3. What would be the key need and cost areas created by HIV/AIDS?

4. What is the magnitude of current and projected need, as a result of HIV/AIDS spreading into the wider society?

5. What are the cost implications within current practice?

6. What is the regional variation of need and cost likely to be and over what time frame?

7.   Is current practice cost-efficient?

8.   What is the status of each sector's response to HIV/AIDS? For priority sectors:

   (a)   *Has the sector quantified the impact of HIV/AIDS on the need for its services or functions?*

   (b)   *Have strategic options been identified? These should include prevention options and options to manage HIV/AIDS impact.*

   (c)   *Have options that are affordable and sustainable, cost-effective and that promote the public good, been identified and prioritized?*

   (d)   *Have key efficiency improvements been identified?*

9.   Has a strategic plan been developed that takes HIV/AIDS issues into account? Is it comprehensive? Does it deal with the internal and external impact of HIV/AIDS on the sector?

10.   Does the sector's strategic plan address equity concerns?

11.   What is the status of inter-sectoral action?

12.   How do sectors currently deal with overlap or gaps in responsibilities, to ensure planning for a multisectoral and integrated response?

13.   Can the responsibilities of various sectors for managing the impact of HIV/AIDS be identified? For example, what aspects of the care of orphans would the Ministries of Education, Health and Welfare coordinate, respectively, and how would functions undertaken by different Ministries be integrated?

14.   What is the impact of HIV/AIDS likely to be on the total government revenue?
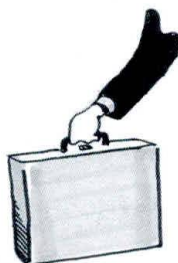
(b) Policy and legislation

Do any current or planned policies and legislation related to the sector:

1. Increase or decrease the rate of spread of HIV infection?

2. Provide the increasing numbers of people living with or affected by HIV/AIDS adequate protection against discrimination?

3. Require adaptation to meet new implementation challenges because of HIV/AIDS?

HOW to respond?

Below are suggestions concerning the scope of possible responses by Ministries of Finance. Some responses may actively mobilize Government Ministries to address impact. Others may target mobilization and regulation of the private sector.

Whatever the response, involve all relevant stakeholders in both the planning of impact assessment, and in its implementation.

Policies and priorities

1. Promote the inclusion of specific HIV/AIDS objectives and activities in all plans and budgets submitted to the Ministry of Finance.

2. Ensure that current expenditure reporting systems encourage appropriate allocation of resources to HIV/AIDS.

3. Increase government spending in areas of major need.

4. Give priority to expenditures that fund cost-effective interventions or represent a strategic investment in planning and capability-building to meet future increases in need.

5. Recognize the critical role of expenditure on broader social and economic development, and in areas such as welfare, to combat the spread of HIV and reduce vulnerability to impact.

6. Communicate to planners and institutions, as soon as possible, an indication of overall expenditure policy in response to HIV/AIDS, and the scale of possible increases, to guide the planning of responses.

7. Ensure that projects, especially large-scale ones, include HIV/AIDS impact assessment and prevention.

8. Give active support to priority HIV/AIDS responses by the private sector. Consider ways of awarding tax relief for innovative responses in prevention, support for community assistance in orphan care, or contributing to the financing and running of hospices and home-based care and support centres.

9. Ensure that incentives and regulations, for example medical scheme regulations, promote, with equity, adequate care of people living with HIV/AIDS.

10. Optimize the role of the private health sector in HIV/AIDS care. Issues which may be considered include the following:

    - Requirement that private medical schemes share with Government information on the sustainability and cost effectiveness of various HIV/AIDS (and other high-cost) care options.

    - Development of mechanisms to ensure that private health-care patients do not drain scarce public sector care resources intended for the poor, following cost-ineffective use of private health-care funding.

11. Ensure that policies and procedures for preventing occupational HIV infection are clear, draw on available resources, and include coverage of hospitals, the uniformed services, transport sector, and prisons.

Costs of action

Trends show increased financial resources for HIV/AIDS. Globally, total international donor disbursement to affected countries for HIV/AIDS programmes grew significantly from US$ 297 million in 1996 to US$1.8 billion in 2002. In the same period, national governmental and NGO spending in affected countries exceeded US$ 500 million.

In terms of geographic distribution, in both 1999 and 2000, the largest share of international donor assistance for HIV/AIDS was destined for sub-Saharan Africa, with the Asian and Pacific region ranking second. Spending on HIV/AIDS has been increasing in absolute terms. Between 1996 and 2002, spending on HIV/AIDS from all sources is estimated to have increased from US$ 500 million to approximately US$ 3 billion.

Resource need and availability

As the HIV/AIDS pandemic grows, available funding is not matching the needs of countries in its path. Significant new resources are required to address the HIV/AIDS pandemic in low- and middle-income countries.

By 2007, prevention costs would represent 39 per cent of total funding needs, ARV therapy-funding requirements would increase to 25 per cent, and treatment for opportunistic infections would be 8 per cent of total funding. It is estimated that, in 2005, US$10.5 billion, and in 2007, US$ 15 billion would be needed annually to expand the global HIV/AIDS response to a point at which the spread of the pandemic could be reversed and its impact significantly diminished. By 2007, low- and middle-income countries in the ESCAP region would need US$ 7 billion, that is, almost one-half of the total resource requirements. Such a funding level would require a dramatic increase in global resources for HIV/AIDS.

The US$ 10.5 billion and US$ 15 billion estimates for 2005 and 2007, respectively, do not include infrastructure development costs. The WHO Commission on Macroeconomics and Health has estimated that, if infrastructure development costs were to be included, US$ 13.6 billion and US$ 15.4 billion would be needed for HIV/AIDS prevention and care, respectively, in 83 selected low- and middle-income countries by the year 2007, in addition to what was currently spent.

Box 11. Global resources needed by region
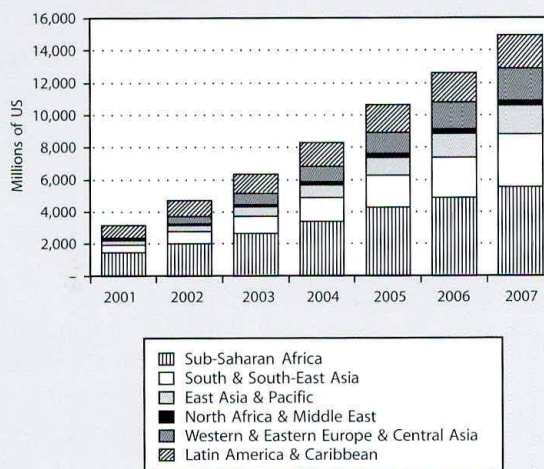
Source: UNAIDS, "Financial resources for HIV/AIDS programmes in low- and middle-income countries over the next five years" (UNAIDS/PCB(13)/02.5).

It is estimated that, already in 2003, it would take US$ 3.5 billion to bridge the gap between total funding needs and funding availability for fighting HIV/AIDS globally. As for the ESCAP region, conservative estimates suggest a resource gap of 80 per cent between resource need and availability for mounting an effective HIV/AIDS response.
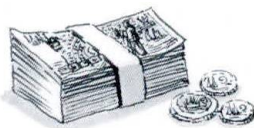
Ministry of Education

STEPS DESCRIBED IN THIS SECTION

WHY?

Introduces the role of the Ministry of Edcuation in tackling HIV/AIDS

WHO?

Identifies key actors for national responses

WHAT?

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The impact of HIV/AIDS on communities served by the Ministry of Education would be profound. Furthermore, the Ministry is uniquely placed to reduce the future HIV/AIDS epidemic as it can influence the risk behaviour of large numbers of young people, many of whom are not yet infected.
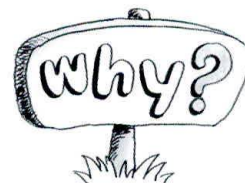
School enrolments are likely to fall as students are taken out of school to care for ill parents and family members. Poor families are particularly likely to suffer this impact and would face increasing difficulty in paying school fees and other related expenses. Girls, in particular, are likely to be taken out of school to care for ill family members.

High levels of new HIV infection among learners, while they are in the education system and afterwards, would represent enormous human costs, and "wasted investment" in education. The major financial loss to education would usually be "waste" of basic state subsidies of education for learners who later die of HIV/AIDS. However, certain bursary or loan mechanisms may be vulnerable to HIV/AIDS among beneficiaries and their families. Needs created by HIV/AIDS in other sectors may limit budgets available for education. Exposure of certain learners (e.g., student nurses) to infection during training may create liabilities for institutions, although the main risk of infection would usually be through sexual activity.

Sickness and death in families and among friends would affect many learners' morale, socialization and performance. Many learners would have new special needs. Among them would be children orphaned by the death of parents from AIDS and learners who themselves are living with HIV. HIV/AIDS would be a challenge to education at primary, secondary and tertiary levels.

Many learners would themselves have been infected by HIV at birth, or through sexual abuse, and sexual activity, including sex work. Stigmatization of HIV/AIDS worsens all impact on learners.

HIV/AIDS may, over time, reduce the number of school entrants and change the age structure of the population.

At the same time, AIDS may lead to a reduction in the number of qualified teachers and administrators, and make it impossible for the education system to fulfil its mandate and provide children with quality schooling. The effects could be especially harsh in rural areas where schools often depend on one or two teachers.

Unless adequate prevention and impact mitigation measures are put in place, countries in the region that have reached high standards of literacy and education could see some deterioration in terms of quality and loss of skilled personnel. Those countries still striving to reach the goal of providing quality education for all could see their efforts stall in the face of HIV/AIDS.

WHO should take the initiative?

who?

Leaders wanted!

- Minister of Education;
- Secretary, Department of Education;
- Focal point in Ministry that coordinates with the National AIDS Committee;
- Teachers' unions, school associations, non-governmental and community groups involved in education-related work.

WHAT needs to be done?

Below is a checklist of questions that guide the type of assessment that needs to be carried out regarding the functions of the Ministry of Education:

(a) New HIV infections among learners

1. What are the levels of HIV infection among learners and recent graduates at various levels of the system?

2. Are there HIV prevention initiatives in schools?

3. Has the coverage and effectiveness of HIV prevention and life-skills programmes been evaluated?

4. Have they been strengthened wherever appropriate?

5. Are there existing or expected skill shortages, which may worsen due to HIV/AIDS impacts on learners?

6. Do curricula and courses at all levels help learners to reduce behaviours associated with HIV risk and ensure returns on investments in education?

(b) Ability to access basic education and new special needs

1. Is there evidence of reduced school enrolment and by how much?

2. Which States/provinces or regions are most affected?

3. Is school attendance reduced due to HIV/AIDS?

4. Is there evidence of an increased drop-out rate or repetition of grades?

5. What are the characteristics of learners who drop out and who repeat grades?

6. Are these orphans? Girls/young women? Children from poor households?

7. Do educators have the understanding, skills and support to recognize and respond to special needs created by HIV/AIDS?

8. What is the extent of disruption of learning due to absenteeism and attrition of teachers?

9. Which provinces or regions are most affected by such disruption?

10. Does the design of buildings need to be modified to enable schools to cope with special needs, e.g., increased need for sick bays, counselling areas, and flexible classroom sizes?

(c) Future numbers of learners

1. What is the expected number of learners at each level of education, given the HIV/AIDS epidemic?

2. What are the implications for staffing and infrastructure planning?

(d) Financial implications

1. Is the sustainability of financial assistance programmes vulnerable to HIV/AIDS impact on beneficiaries?

2. Are any learners at risk of exposure to HIV infection in the course of their training?

3. Are the training institutions involved ensuring appropriate education and adequate supplies of protective equipment?

(e) Policy and legislation

Are any current or planned policies and legislation related to the education sector likely to:

1. Increase or decrease the rate of spread of HIV infection?

2. Provide adequate protection against discrimination for the increasing numbers of people living with HIV/AIDS and affected by it?

3. Require adaptation to meet new challenges to implementation because of HIV/AIDS?

HOW to respond?

The following are responses that the Ministry of Education could take to reduce HIV spread.

(a) New infection among learners

1. Develop strategies to slow the rate of new infections in pupils: these may include life skills programmes emphasizing HIV/AIDS education.

Box 12. Catching them early

In 1992, Thailand launched national strategies to reduce the vulnerability of children, especially girls, at risk of entering the sex industry, and contracting STIs and HIV.

The Ministry of Education (MOE) conducted a survey of Thai sex workers, gathered data on villages with high HIV/AIDS rates, and collected information on the number of students who finished Grade 6, but who did not continue their education. These were used as a basis for planning interventions.

Prevention measures were viewed as the most important strategy. However, prevention, assistance, rehabilitation, and legal measures to eliminate entry into the sex industry by children under 18 were also imperative.

These preventive measures identified guidelines for intervention that included those below:

- The provision of 9 years of quality basic education and/or vocational training for all children and youth;

- Equal access for girls and boys to both formal and non-formal education;

- Awareness-raising campaigns against child sex work;

- Counselling and guidance services, in particular for solving family and young people's problems and for job selection – in every school and for out-of-school children and youth.

Source: UNAIDS, Summary Booklet of Best Practices: National strategies to reduce vulnerability of Thai girls (Thailand) (*http://www.unaids.org/bestpractice/summary/cyp/natstrat.htm,* 4 April 2003).

2. Use the findings and outcomes of programmes that are in place to strengthen them, as appropriate, including through effectiveness evaluations.

3. Scale up interventions once these have been shown to be effective.

4. Consider fee exemption or bursaries for girls and young women to reduce economic pressures to engage in sex work.

5. Implement effective strategies to eliminate sexual abuse and rape of learners in educational institutions.

(b) Ability to access basic education and new special needs

1. Explore ways of providing bursary schemes for poor pupils: consult with local communities to ensure bursary recipients are able to attend school.

2. Develop protocols and institute training to help teachers respond to the special needs of all pupils and orphans whose parents have died of AIDS.

3. Include HIV/AIDS education for teachers in all in-service training initiatives.

4. Require teacher-training institutions to provide HIV/AIDS education.

5. Liaise with other Government Ministries to develop a care programme for children who have lost their parents to AIDS, and decentralize implementation to the local level.

Box 13. Going beyond the obvious: adapting education

AIDS makes it necessary to devise new ways of turning education against the epidemic. School planners and policy-makers envision alternative forms of schooling, such as schooling structured around modules and semesters rather than around age-linked grades. With a project in 11 African countries, the US Agency for International Development (USAID) helps schools emphasize classroom-based prevention, life-skill messages, as well as programmes for children who have dropped out of school to care for ailing parents or because they must work to support the household. Among the interventions is an interactive radio education programme that was piloted in Zambia in order to provide an education for orphans and vulnerable children. The AIDS Support Organisation (TASO) – a Ugandan group that has traditionally provided support for people living with HIV/AIDS – found that the major concern of parents caring for orphaned and vulnerable children was the costs associated with attending school. TASO now supports 232 primary, secondary and vocational education students by providing school fees and teaching materials. The programme also trains teachers in basic counselling skills and offers child/guardian workshops so that guardians and children have a forum for discussing, and finding solutions to, their problems. Calling on retired teachers offers another means of coping with education systems strained as a result of AIDS.

Source: UNAIDS, *Report on the global HIV/AIDS epidemic* (Geneva , 2002), p. 53.

(c) Future numbers of learners:

1.   How may staffing and infrastructure planning take into account HIV/AIDS impact on the size and structure of the learner population?

2.   How may the impact of AIDS on attrition and absenteeism among teaching staff be factored into planning?

Ministry of Labour

STEPS DESCRIBED IN THIS SECTION

WHY?

Introduces the role of the Ministry of Labour in tackling HIV/AIDS

WHO?

Identifies key actors for national responses

WHAT?

Contains a checklist of questions that identifies priorities

HOW?

Suggests appropriate action responses

HIV/AIDS hits the world of work in numerous ways. In badly affected countries, it cuts the supply of labour and reduces income for many workers.

Increased absenteeism raises labour costs for employers. Valuable skills and experience are lost. Often, a mismatch between human resources and labour requirements is the outcome. Along with lower productivity and profitability, tax contributions also decline, while the need for public services increases. National economies are being weakened further in a period when they are struggling to become more competitive in order to weather the challenges of globalization.

Most countries impose an obligation on employers to do all in their power to ensure that their employees are not put at risk of illness or injury because of the nature of their work. The most clear-cut examples of work-related HIV/AIDS risk are those situations in which health-care workers are exposed to contaminated blood or blood products. Police and prison personnel may also be exposed to HIV through human bites. In these instances, employers are obliged to provide protective gloves and other equipment, and education.

Misconceptions about work-related transmission may need to be cleared up to prevent workers living with undue stress and preju-dice. Less clear-cut and more contentious as work-related exposure, are situations that predispose employees to high-risk sexual encoun-ters, such as frequent and lengthy travel away from home. Trans-port workers, seafarers or construction teams are among such vulnerable employees.

For workers already living with HIV/AIDS, early and appropriate treatment can extend the length of working life and minimize productivity impact. This extension of working years is to the

advantage of the workers, their families, employers and the state. As early treatment is dependent on early disclosure of HIV status, non-discriminatory policies and access to counselling which facilitate early disclosure need to be supported.

Early disclosure also gives employers the opportunity to mitigate the impact of employee infections on the organization, such as instituting multi-skilling, planning skills development and timely recruitment of replacement staff. Training courses may be inefficient, if HIV/AIDS affects recipients before they utilize skills.

Efforts to maintain stable and cooperative labour relations may be undermined, if HIV/AIDS is poorly managed within companies. The Ministry of Labour, together with unions and employer group-ings, may have a critical role in encouraging the formal and informal sectors to manage HIV/AIDS issues appropriately.

HIV-positive individuals have the potential to lead productive lives for many years. There is general agreement that pre-employment testing is misguided, expensive and unfair. Even in situations where pre-employment testing or pre-training testing is not conducted, people thought to have HIV/AIDS may be discriminated against in companies. This may be through employers not employing from groups thought to engage in high-risk behaviours or denying HIV-positive people career advancement opportunities.

HIV/AIDS may affect the numbers claiming from any unemploy-ment protection fund or other benefit fund. Such funds may have barriers to the chronically ill collecting benefits, thereby discriminat-ing against people living with HIV/AIDS.

The impact of HIV/AIDS includes the following:

- Skills shortages in some areas (e.g., mines and other industries that are reliant on migrant labour), with a rise in labour costs;
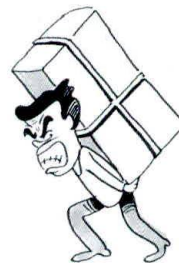
- Reduced supply of labour;

- Loss of skilled and experienced workers;

- Absenteeism and early retirement;

- More people may need skills development;

- Stigmatization of and discrimination against workers with HIV;

- Increased labour costs for employers from health insurance to retraining;

- Reduced productivity in certain sectors and businesses, contracting tax base and negative impact on economic growth;

- A threat to food security as agricultural workers are increasingly affected;

- Falling demand, investment discouraged and enterprise development undermined;

- Social protection systems and health services under pressure;

- Increased burden on women to combine care and productive work;

- Loss of family income and household productivity, exacerbating poverty;

- Orphans and other affected children forced out of school and into child labour;

- Pressure on women and young people to survive by providing sexual services.

"HIV/AIDS should be recognized as a workplace issue, and be treated like any other serious illness/condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic."

ILO, The ILO Code of Practice on HIV/AIDS and the World of Work (Geneva, 2001)

WHO should take the initiative?

Leaders wanted!

- Minister of Labour;
- Secretary, Department of Labour;
- Focal point in the Ministry that coordinates with the National AIDS Committee;
- Trade unions, employers' associations, non-government and community groups involved in labour-related work.

WHAT needs to be done?

Below is a checklist of questions that guide the type of assessment that needs to be carried out regarding the functions of the Ministry of Labour:

(a) Employment planning, efficiency and productivity:

1. What is the projected number of workers living with HIV/AIDS, workers ill from HIV/AIDS, and AIDS-related deaths for various sectors, industries, job categories and parts of a country?

2. What sectors and institutions are at high risk of productivity and efficiency losses?

3. Which of these sectors are unlikely to cope with expected losses?

4. What are future labour costs likely to be, given the loss of skilled workers due to HIV/AIDS?

5.   What are the labour costs for various job categories and different planning areas likely to be?

6.   What are future levels of unemployment likely to be?

7.   What are the likely key skill shortages in the country and in specific industries?

8.   How can the Ministry encourage companies to assess their vulnerability to HIV/AIDS impact and to formulate appropriate responses?

9.   How can employers and trade unions be encouraged to provide access to counselling and safe entry points for HIV-positive workers?

10. What health facilities are available to workers?

11. How may the Ministry of Labour promote early and appropriate treatment of HIV-positive persons, in conjunction with the health facilities available to workers?

(b)   Labour relations

1.   What HIV/AIDS policy, legislation and guidelines are currently available for employers, and are there any gaps in policy?

2.   Are there any indications as to how well HIV/AIDS workplace policies are distributed?

3.   What sectors or parts of the country are poorly serviced by labour policy and information?

4.   How do employers and trade unions currently approach HIV/AIDS issues in the workplace? For example, do companies still practice pre-employment screening? Are HIV-positive workers barred from further training or promotion in some firms?

5.   How well would internal labour relations mediators and external consultants handle HIV/AIDS issues as they arise?

(c) Employment equity

1. Does current legislation ensure adequate protection for HIV-positive employees?

2. Are there any mechanisms in place for implementation and monitoring of good labour practice in relation to HIV/AIDS?

(d) Occupational health and safety

1. What are policy and protocols for preventing work-related HIV infection in hospitals and other at-risk institutions?

2. Are these in line with good practice?

3. How can employers be encouraged to decrease the exposure of employees to high-risk situations?

4. How can trade unions in high-risk industries be encouraged to promote prevention and awareness initiatives?

5. How can large employers and trade unions be encouraged to provide effective counseling services for HIV-positive workers?

(e) Benefit packages

1. What criteria are used to assess HIV/AIDS-related disability?

2. Are these in line with good practice?

3. Are HIV/AIDS disability criteria widely applied?

4. Is there equity of access to any social security benefits?

5. What are the current and on-going costs of benefit claims?

6. What are future costs likely to be?

(f) Policy and legislation

Do any current or planned policies and legislation related to the labour sector:

1. Increase or decrease the rate of spread of HIV infection?

2. Provide, for the rising numbers of people living with HIV/AIDS and affected by HIV/AIDS, adequate protection against discrimination?

3. Require adaptation to meet new challenges to implementation because of HIV/AIDS?

HOW to respond?

The Ministry of Labour is uniquely placed to impact profoundly on the HIV/AIDS epidemic. It has the responsibility of programmes, policies and legislation that target productive age adults, in the prime of their lives, whose behaviours place them at high risk of acquiring HIV and who are most affected by HIV/AIDS illness and death.

(a) Employment planning and efficiency and productivity

1. Use projections of HIV prevalence, illness and AIDS deaths by sector and/or job category for planning and advocacy.

2. Use labour cost projections in planning, if appropriate.

3. Use skill audits in planning employment and training.

4. Expand skills development programmes to meet future demands.

Box 14. Reaching outside the formal economy

Workers outside the formal economy are too often ignored in public health efforts. Yet, in many low- and middle-income countries, the informal economy employs far more people than do the public or formal private sectors. These workers typically lack income security, health insurance and other benefits, and seldom enjoy labour law protection. Owing to the obstacles to their entry into the formal job market, women often represent the majority of those in informal work, making them even more vulnerable to the economic effects of the epidemic. Enterprises in the informal economy are usually small and labour-intensive, relying heavily on one or a few operators. When a worker falls sick and eventually dies, it can be very difficult for these small enterprises to stay in business. The precarious nature of informal employment, the lack of social protection and limited access to health services also worsen the impact of the epidemic for individual workers. Workers in the informal economy are often organized into associations or groups, and the ILO works with several of these. Increasingly, this assistance includes training for AIDS prevention and social protection measures such as health insurance. Work among micro- and small enterprises includes a business awareness programme for sex workers and the 'Start and Improve your Business' programme, which is integrating HIV/AIDS into training in Africa. Other programmes offer technical support for the setting up and strengthening of local micro-insurance schemes in order to increase access to heath-care. A pilot project is under way in Burkina Faso to adapt this approach to HIV/AIDS-related needs.

Source: UNAIDS, *Report on the global HIV/AIDS epidemic* (Geneva, 2002), p. 110.

5. Develop, with stakeholders, policy and legislation that encourage employers and trade unions in vulnerable sectors to conduct effective workplace HIV prevention programmes.

6. Disseminate information to employers in the most vulnerable sectors or organizations concerning HIV/AIDS vulnerability.

7. Disseminate resources and good practice case studies, which describe actual responses to HIV/AIDS by some companies. Case studies may include:

   (a) HIV prevention initiatives;
   (b) Managing ill health;
   (c) Human resource development and industrial relations;

(d)   Employee benefits and survivor support;

(e)   Monitoring and planning.

8.   Plan innovative and non-coercive ways to encourage all companies, or companies within specific sectors, to respond to HIV/AIDS.

9.   Introduce a Ministry award for good practice, arrange media coverage and appropriate publicity.

10.   Liaise with other government ministries, as appropriate, to introduce a requirement that companies adhere to minimum standards of good practice in HIV/AIDS, to qualify for government contracts.

11.   Liaise with appropriate stakeholders to explore ways of awarding tax relief for priority HIV/AIDS responses that exceed what would ordinarily be expected. For example, such responses may include actively assisting communities with orphan support or contributing to the financing and running of terminal support and home-based care support centres.

(b)   Labour relations:

1.   Disseminate the ILO "Code of Practice on HIV/AIDS and the World of Work" to employer groups, individual employers, and trade unions, particularly sectors or parts of the country that are poorly serviced by information.[2]

2.   Organize training courses for labour relations mediators on HIV/AIDS issues, if applicable.

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[2]   ILO, *The ILO Code of Practice on HIV/AIDS and the World of Work* (Geneva, 2001), electronic version available at (*http://www.ilo.org/public/english/protection/trav/aids/code/languages/hiv_a4_e.pdf*,   2001).

Box 15. A model employer

The Haiha-Kotobuki joint venture became involved with the Viet Nam Chamber of Commerce and Industry (VCCI), CARE International and the National AIDS Committee (NAC) in a project to promote business partnerships to assist the efforts of the Government of Viet Nam to prevent and control HIV and AIDS. The project attempts to do this by:

- Increasing knowledge and awareness of the risk of HIV/AIDS and skills for protection within the business community;
- Piloting a model of HIV/AIDS education within the workplace; and
- Developing policy with recommendations to encourage domestic and foreign companies to contribute to HIV/AIDS programmes in their workplace.

Top management support was needed for such an initiative. VCCI identified a high-ranking and highly committed member of the Haiha-Kotobuki joint venture. A large number of company staff were also willing to be involved and trained in emerging social issues that impinge upon their business. Corporate leadership meant corporate responsibility in matters related to their staff, their families and the wider community. One major activity undertaken by Haiha-Kotobuki was the development of an HIV/AIDS workplace policy. The policy assists managers and workers in taking the initiative to protect themselves, their families and the community against HIV/AIDS, as well as providing care and support for PLWHA in the company. Haiha-Kotobuki identified five major categories:

- Implementation of prevention programmes;
- Testing;
- Confidentiality;
- Preventing discrimination;
- Flexible work conditions for HIV-positive staff.

Staff who may be living with HIV are treated equally and have access to all company benefits, including holiday allowance, social and health insurance, emergency support and free lunch in the company cafeteria.

Source: Peter R. Lamptey and Helene D. Gayle eds., *HIV/AIDS prevention and care in resource-constrained settings: A handbook for the design and management of programs* (Family Health International, Arlington, 2001) p. 16.

(c) Employment equity

1. Develop pilot mechanisms to monitor good labour practice in relation to HIV/AIDS.
2. Consider ways to encourage female participation in the labour force.

(d) Occupational health and safety

1. Ensure that good practice procedures for preventing work-related exposure to HIV, and procedures for HIV prophylaxis in the event of exposure, are in place in relevant institutions.
2. Encourage trade unions in high-risk sectors to conduct HIV prevention programmes.
3. Assist trade unions to source condoms and to develop HIV/AIDS education materials.
4. Facilitate, with relevant stakeholders, the development of HIV prevention through peer educator strategies in the workplace.
5. Mobilize resources for developing training materials, such as videos, slide shows and resource directories, that may be used by peer educators.
6. Encourage employers to provide counseling services for HIV-positive workers, where feasible.

(e) Benefit packages:

1. Facilitate the development and dissemination of functional criteria for HIV/AIDS disability.
2. Ensure the removal of any barriers that the chronically ill may face in collecting benefits.
3. Consider ways of protecting informal sector labour that may be at risk of HIV, but have poor access to benefits.
4. Plan for future costs of unemployment insurance, where relevant.

Ministry of Welfare

STEPS DESCRIBED IN THIS SECTION

WHY?

Introduces the role of the Ministry of Welfare in tackling HIV/AIDS

WHO?

Identifies key actors for national responses

WHAT?

Contains a checklist of questions that identifies priorities

HOW?

Suggests appropriate action responses

The impact of HIV/AIDS on households is potentially disastrous, especially in a region where over 800 million people are estimated to live below the poverty line of less than US$ 1 per day. Those most likely to acquire the virus are generally in the prime productive age group of 15 to 49 years, who are often at the peak of their earning capacity.

As people living with HIV/AIDS succumb to illness, their income earning abilities weaken. At the same time, household or family incomes shrink, when family members have to adapt their work lives to care for the ill. Studies show that the incomes of households with a person living with HIV/AIDS can fall by as much as 80 per cent.

As incomes become depleted, household savings are often tapped to meet health-care costs associated with HIV/AIDS. Studies in the region suggest that over half of all households affected by HIV/AIDS reduced their consumption of goods and services by 40 to 60 per cent, in order to help meet health-care costs.

As more and more people living with HIV progress to AIDS, the financial and material burden of care tends to shift away from hospitals towards family and friends, through home- and community-based care. AIDS deaths, following asset and wage losses, and care costs, often push households deeper into poverty.

Forms of social relief available to the destitute differ among countries of the region. The budgetary implications of HIV/AIDS are obviously a major consideration and the impact of HIV/AIDS on eligibility for support and uptake would need to be quantified. This is particularly important in countries where statutory state support is provided.
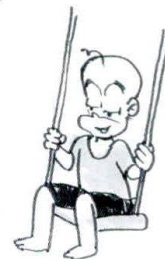
In countries with severe epidemics, the most pressing welfare concern that has been identified is that of the need to care for children orphaned through parental death from AIDS. Large numbers of AIDS orphans may be left unsupported, as extended family structures and networks break down or household resources become over-extended. There could be an increase in the number of homeless children, who themselves would become vulnerable to HIV infection. Many children might be unable to attend school because of household financial constraint.

In all countries with severe epidemics, the support of affected communities would help avert large-scale social problems. Overall need and demand for welfare assistance could increase. In the long-term, while the need for old age pensions might decrease, as fewer people reach pensionable age, there might be more pensioners qualifying for state assistance, as the proportion of people in the low-income bracket increases as a result of the economic impact of HIV/AIDS on households. The need in provinces or regions of a country would differ: in some areas, HIV/AIDS-related need would be delayed, while others might experience sustained need.

The statutory work load of state social workers could increase, with higher eligibility for foster care grants and other social support and increased numbers of foster homes that require supervision. There could be increased referrals from local government and its housing department for intervention in housing problems. Prevention and community development activities may be swamped by statutory work demands.

Welfare policies and programmes have the potential to foster the creation of an environment in which the most vulnerable could protect themselves from the full negative impact of HIV/AIDS.

Policies and programmes that support women and children who otherwise might be vulnerable to pressure to engage in sex work as a means of survival, and policies on orphan support, are critical to

stemming a future epidemic, and to dealing with the impact of the current one. Clear understanding of potential impact would influence whether the welfare response is appropriate and effective in meeting the needs of society and individuals.

WHO should take the initiative?

- Minister of Welfare;
- Secretary, Department of Welfare;
- Focal point in Ministry that coordinates with the National AIDS Committee;
- Non-government organizations and community groups involved in welfare-related work.

WHAT needs to be done?

Below is a checklist of questions that guide the type of assessment that needs to be carried out regarding the functions of the Ministry of Welfare:

(a) *Administration of social security grants and other poor relief*

1. What is the expected impact of HIV/AIDS on eligibility and uptake of social security grants or other forms of poor relief?

2. What are the budgetary implications of the welfare impact of HIV/AIDS?

3. What is the sub-national-specific impact of HIV/AIDS?

4. How may data on impact be used to assist in sub-national resource allocation and in channelling more resources to areas of greatest need?

5. What are the responsibilities of various sectors and other players in contributing to safety nets for the most vulnerable?

6. Are these resource-efficient and complementary?

7. Are appropriate linkages in place?

8. What are the gaps and overlaps in responsibility?

(b) Care of orphans and children affected by AIDS

1. What are the projected numbers and provincial or regional distribution of orphans (girls and boys)?

2. What is the level of vulnerability of orphans?

3. What are existing community care mechanisms for orphans?

4. Has appropriate government policy been developed to address the needs of orphans?

5. What are the good practice examples or innovative models of care that could be adapted or scaled up?

6. What are the costs of current and desired policies and programmes?

7. How can sustainable funding be mobilized for these?

Box 16. Home and community care

In an attempt to address the growing problem of HIV/AIDS care in Cambo-dia, WHO started a joint pilot project in home and community care in 1997, in collaboration with the Ministry of Health and local and international NGOs. The project sought to develop ways to provide appropriate support through government/NGO collaboration within the government policy of health reforms. Using the framework of WHO's Comprehensive Care Across the Continuum, eight home-care teams were established across the city of Phnom Penh. Based in government health centres and working within their boundaries, the teams formed a network of caregivers supporting patients and families at home.

The following comprise the primary focus in health-care: At least two members of each 5-person team are nurses. Social and emotional support is given high priority, as well as raising general awareness about HIV/AIDS within families and the community at large. Depending on need, 1 or 2 members of the team may make several visits a week, during which they show the family how to manage symptoms simply and safely, and support both family and patient as best they can. Although they carry simple drugs and supplies and have some welfare funds, team members encourage the family to buy essential items. Emphasis is placed on maintaining good hygiene and nutrition. A team's activities may also include accompanying a newly-diagnosed patient to a support group, educating monks concerned about contamination on negotiating treatment options with a traditional healer. Local volunteers assist the teams in their work – for example, in finding a particular house in Phnom Penh's urban sprawl, or providing liaison with community leaders.

Each team is made up of both government and NGO staff, all of whom operate under the same terms and conditions. The project is coordinated through a committee of members representing all partners, including the 7 NGOs and the health-centre managers. Monthly team activity reports are submitted to the committee for discussion. Representatives from the teams themselves meet weekly to exchange news, pass on referrals and provide mutual support. Senior health workers and NGO staff carry out

on-site supervision. Hospital doctors support the teams with regular medical consultations at the homes of seriously ill patients unable or unwilling to go to hospital.

The practice of sharing resources helped both the NGOs and the Government. Working on an equal footing towards a common goal enabled both "sides" to share their different skills and experiences and learn from each other. This has helped normalize relations between NGOs and Government, which are sometimes strained. Some government staff members believe that the lion's share of resources go to NGOs, which often adopt conflicting and unsustainable approaches. NGOs, in turn, may complain of poorly managed government facilities.

A new problem has emerged: Creating an equal team required supplementing government staff salaries (normally between US$ 8 and US$ 15 per month) to a realistic level. The extent to which this creates a problem needs further analysis. Low salaries are a constant source of frustration in Cambodia. Until this is addressed, salary supplementation will be difficult to avoid if the Government is to be included in innovative projects.

Source: Peter R. Lamptey and Helene D. Gayle eds., *HIV/AIDS prevention and care in resource-constrained settings: A handbook for the design and management of programs* (Family Health International, Arlington, 2001) p. 16.

(c) Statutory work and community development

1. What are the HIV/AIDS implications for equity of service provision?

2. How do equity concerns affect staff and infrastructure planning?

3. Can grant application procedures be streamlined to be more time-efficient?

4. Would increased statutory work load and other forms of HIV/AIDS-related impact lead to the neglect of community development and prevention activities under current service models?

5. What partnerships could be developed with non-governmental organizations and other bodies, for example local authorities?

(d) Policy and legislation

Do any current or planned policies and legislation related to the welfare sector:

1. Increase or decrease the rate of spread of HIV infection?

2. Provide, for the increasing numbers of people living with HIV/AIDS, and for those affected by it, adequate protection against discrimination?

3. Require adaptation to meet new challenges to implementation because of HIV/AIDS?

HOW to respond?

The responses suggested show how the Ministry of Welfare could take action to reduce HIV spread.

Box 17. Music brings the message

Over the past five years, the UNAIDS Secretariat and some of its cosponsors have worked closely with Music Television (MTV) in an effort to reach out to young people and talk to them in their language about issues that interest and involve them. This unique partnership has built on MTV's strengths as a global television network and leading multimedia brand for young people, using their distribution platform and rights-free distribution to other broadcasters to reach some 900 million households worldwide with HIV/AIDS messages. The partnership has included the production of an award-winning series, 'Staying Alive', focusing on the lives of individual young adults living with HIV/AIDS around the world. In addition to being shown on all MTV channels, the series has been aired by many major networks, including China Central Television, South African Broadcasting Corporation, TV Africa, Channel News Asia and RTR Moscow, to name a few. Together with UNAIDS, MTV has encouraged many celebrities to record prevention messages that have been widely distributed and used in public service announcements in many countries. A booklet for MTV presenters and celebrities, entitled *Talking about AIDS*, has also been produced.

Source: UNAIDS *Report on the global HIV/AIDS epidemic* (Geneva, 2002). p. 112.

(a) *Administration of social security grants and other poor relief*

1. Consider the feasibility of providing HIV/AIDS prevention and care messages to social security grant recipients and households.

2. Seek increased budgets and adjust budget allocations in the light of impact assessments and projections.

3. Incorporate HIV/AIDS impact into poverty indicators.

4. Adjust sub-national resource allocations, taking into account the sub-national-level impact of HIV/AIDS on poverty.

5. Ensure resources are directed towards poor relief and poverty reduction in areas of greatest need.

(b) Care of orphans and children affected by HIV/AIDS

1.   Prepare policy documents and projects to address the needs of orphans, where appropriate, including streamlined provision and support of foster care, bursary provision to assist education, and provision of extra support for the schooling of orphans who might have special education needs.

2.   Adapt and scale up innovative models of care that have been proved effective.

3.   Mobilize and coordinate support for policy and project implementation.

4.   Develop appropriate indicators and systems to monitor numbers and circumstances of orphans and other children made vulnerable by HIV/AIDS.

5.   Liaise with Ministries of Education and Health, where relevant.

6.   Consider ensuring that any projects to address the needs of orphans include HIV/AIDS prevention messages, if appropriate.

(c) Statutory work and community development

1.   Ensure that staffing and infrastructure planning take into account the demographic and economic impact of HIV/AIDS.

2.   Ensure that projects and programmes are directed to areas of greatest need.

3.   Seek allocation of more social worker posts, if appropriate.

4.   Streamline grant application procedures to be more time-efficient.

5.   Consider the appropriateness of personnel assignment: for example, dedicated personnel for statutory work and dedicated personnel assigned to community development and prevention.

Ministry of Agriculture

STEPS DESCRIBED IN THIS SECTION

WHY?

Introduces the role of the Ministry of Agriculture in tackling HIV/AIDS
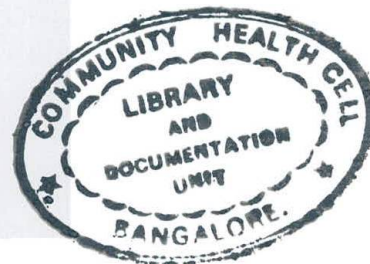
WHO?

Identifies key actors for national responses

WHAT?

Contains a checklist of questions that identifies priorities

HOW?

Suggests appropriate action responses

At first glance, HIV/AIDS may not appear to have a significant impact on agricultural production and rural development at the national level. However, by adversely affecting the livelihood, assets, income and productive capacity of a growing number of rural households, HIV/AIDS could have a severe impact on the availability, access to, and utilization of, food.

Differentials in HIV infection rates between urban and rural areas can quickly be eroded when movement and interchange between the two rise – in this manner, despite a common assumption to the contrary, rural areas are not immune to the epidemic.

For example, the large-scale migration of mostly young rural people to urban areas exposes them to high risk of HIV infection: long absence from home, stressful living conditions and inducement to engage in high-risk behaviour. On return to the rural areas, many transmit the virus to their sex partners. Furthermore, they return to their families for care, once the AIDS symptoms are manifest.

This could dramatically decrease the productivity of the agricultural labour force. The impact of a serious epidemic might be more pronounced where a large proportion of the labour force is employed in the agricultural sector, for example in China, India and Indonesia. In severe epidemics, food production and supplies, even food security, could be threatened, as HIV/AIDS-related morbidity and mortality worsen. For example, in Papua New Guinea, by 2020, rural income is projected to decline by up to 8 per cent in a worst-case HIV/AIDS scenario. The effects on smallholder agriculture could be even worse, with output projected to plunge by as much as 24 per cent over the same period.

Rural poverty, labour migration and the low status of women could increase susceptibility to HIV. For example, men who have to migrate or travel frequently, are more likely to change sex partners, while young women in poverty may be compelled to trade sexual favours for cash or other support.

These factors also make it more difficult for communities and individuals to cope with the impact of existing infections. HIV/AIDS may impact on the rural environment through increasing demands for poverty relief, through making some form of cropping and subsistence agriculture unviable because of labour shortage, and caring for sick family members may increase rural women and children's work burden, leaving them little time for skills development.
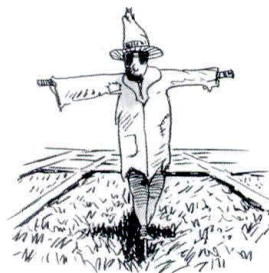
Ministry programmes and policies relating to small-holder farmers, tenant farmers and commercial agriculture may impact on HIV spread. Further, HIV/AIDS may present overwhelming direct and indirect costs to farmers and vulnerable organizations. Absenteeism, recruitment and training are likely to form the bulk of costs to organizations. HIV/AIDS-illness and mortality among the recipients of loans might increase the number of defaulters on loan agreements.

Migrant labourers, seasonal labourers and immigrants may be at particular risk and have few employee benefits. The low status of women and their limited economic independence undermine women's ability to protect themselves from HIV infection.

In fact, in macroeconomic terms, the majority of countries most affected by HIV/AIDS are also those most heavily reliant on agriculture. The issue of HIV/AIDS is thus increasingly relevant to the work of the Ministry of Agriculture and the Ministry of Rural Development. Both Ministries can design policies and strategies to stem the spread of the virus to, and within, rural areas, as well as protect and support rural households already affected by HIV/AIDS.
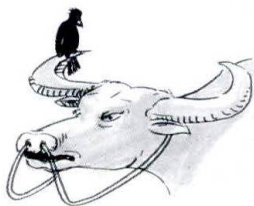
WHO should take the initiative?

- Minister of Agriculture;

- Secretary, Department of Agriculture;

- Focal point in the Ministry who coordinates with the National AIDS Committee;

- Members of local bodies, farmers' associations, rural cooperatives, rural community leaders, non-governmental organizations.

WHAT needs to be done?

Below is a checklist of questions that guide the type of assessment that needs to be carried out regarding the functions of the Ministry of Agriculture:

(a) Promotion of rural development, including poverty reduction, provision for food security, and empowerment of rural women

1. What are the levels of HIV infection and AIDS deaths in rural areas?

2. What are the expected levels of infection and AIDS deaths in the next 5 to 10 years?

3. What kinds of rural households and communities are most susceptible to HIV infection?

4. What is the current and expected impact of increased illness and death on the nutritional status of pregnant and lactating women, children under 5 and older persons in rural areas?

5. Are there parts of the country whose viability would be particularly adversely affected by large numbers of AIDS deaths among adults in the productive age group?

6. Are there HIV prevention programmes linked to current rural development initiatives?

7. Have their coverage and effectiveness been evaluated?

8. Have they been strengthened, where appropriate?

9. How may AIDS illness and death in the household affect rural women's access to health services, education, and other resources and support?

10. What are the special HIV/AIDS-related problems faced by female-headed households in rural areas?

11. Do rural women face different problems in dealing with illness and death in families from those that men face?

12. What is the effect of HIV/AIDS on migration patterns?

13. Would workers living with HIV/AIDS return to the rural areas?

14. What are the likely effects of such return on rural communities?

15. What is the role of employers and the state in supporting workers living with HIV/AIDS in rural areas?

(b) Creation of conditions favourable for small-holder farmers, tenant farmers and commercial agriculture

1. Are there any good practice partnerships or initiatives to reduce HIV spread in rural areas or mitigate its rural impact, which could be modified or replicated?

2. What are current and potential governmental and NGO points of entry for HIV prevention and mitigation in rural areas?

3. Are these points of entry being fully exploited?

4. Could farming systems or areas be classified according to how vulnerable these systems would be to increased illness and death, in the way that labour-intensive farming practices, low food or credit surpluses and insecure land tenure make a system more vulnerable.

5. What is the need for, and feasibility of, expanding credit availability for the poorest farmers?

6. What are the numbers of orphans on farms and agricultural enterprises?

7. How many children on farms and agricultural enterprises are likely to be orphaned in future years?

8. What are the current policies and practices for orphaned children and widows on farms?

9. How would increased numbers of orphans and widows be supported?

(c) Financial assistance and settlement of farmers on state land

What is the likely impact of HIV/AIDS on current and future loan portfolios?

(d) Occupational health and safety strategies

1. What enterprises, geographic areas and occupations are at high risk of HIV/AIDS?

2. What are the patterns and extent of migrant labour in the agricultural sector?

3. Are there any policies and programmes that inadvertently encourage single-sex living arrangements, which might predispose to high-risk situations and behaviours?

4. What is the feasibility and appropriateness of enlarging the scope of activities undertaken by agricultural extension workers to include HIV/AIDS activities?

(e) Rights of agricultural workers and rural dwellers

With regard to surviving children or widows having problems retaining family land, housing or livestock:

1. Do policies and legislation support gender equality and protect the occupancy and inheritance rights of widows and orphaned children?

2. How could implementation of those policies and legislation be monitored and strengthened, where appropriate?

(f) Other projects, schemes and services

Large concentrations of workers moving into an area for a defined project could spread HIV into that area:

1. What system exists to monitor projects that require movement by many workers?

2. How is the risk of HIV transmission related to projects and schemes assessed?

(g) Agricultural training

1. What are the levels of knowledge and awareness concerning HIV/AIDS in training recipients?
2. What is the magnitude of need for prevention messages and condom distribution?

(h) Policy and legislation

Do any current or planned policies and legislation related to the agriculture sector:

1. Increase or decrease the rate of spread of HIV infection?
2. Provide adequate protection against discrimination for the increasing numbers of people infected or affected by HIV/AIDS?
3. Require adaptation to meet new challenges to implementation because of HIV/AIDS?

HOW to respond?

The Ministry of Agriculture has the responsibility of programmes, policies and legislation that target those in the agriculture sector, including adults in the prime of their lives, whose behaviours place them at high risk of acquiring HIV and who are most affected by HIV/AIDS illness and death.

(a) Promotion of rural development, including poverty reduction, provision for food security, and empowerment of rural women

1. Consider using area-specific levels of HIV infection and expected AIDS deaths to inform planning and target appropriate rural development programmes.

2. Mobilize all rural development initiatives, whether public or private, to include HIV prevention programmes, e.g., through including HIV prevention in tender documents.

3. Support appropriately targeted nutrition programmes for rural children, pregnant and lactating women and older persons.

4. Set up partnerships with other Departments or Ministries and employers to find appropriate, cost-effective ways to assist ill rural migrants and their families.

5. Ensure that rural programmes and initiatives take into account the vulnerability of farming systems and areas to increased illness and death in working age adults.

6. Integrate HIV education and condom distribution into agricultural support programmes and activities.

7. Integrate information on the potential economic effects of HIV/AIDS on farming systems into support programmes and activities.

8. Support initiatives to increase locally-generated incomes and reduce the need for migration.

9. Consider encouraging labour-economizing crop varieties and labour-saving technologies and cultivation practices in areas of high HIV prevalence.
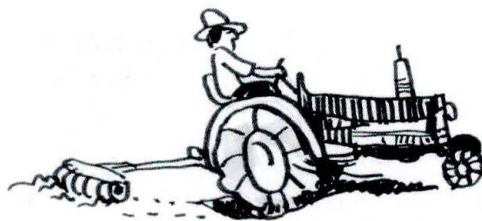
11. Support initiatives that would reduce the work burden of rural women and children, e.g., access to fuel and water supply, especially to benefit households with persons living HIV/AIDS in need of their care.

12. Develop and implement unambiguous and consistent policies that ensure land tenure is secured for widows and orphaned children, to protect them from destitution following the death from AIDS of husbands and fathers who were tenant farmers.

13. Document good practice case-studies and examples for use by farmer organizations and community groups.

(b) Creation of conditions favourable for small-holder farmers, tenant farmers and commercial agriculture

1. Expand credit availability for the poorest farmers.

2. Develop HIV awareness programmes to reduce risk behaviour among small-holder and tenant farmers.

3. Support labour-saving projects that benefit households with persons living with HIV/AIDS.

4. Introduce HIV/AIDS awareness programmes targeting commercial agriculture that include advice on how to mitigate the impact of HIV and ensure employee benefits are sustainable.

5. Encourage commercial farmer organizations and small-holder farmers to develop a response to HIV/AIDS.

6. Liaise with counterpart Ministry of Agriculture and the agricultural sector in other countries to share sector-specific lessons.

7. Support inter-country cooperation to develop responses.

(c) *Financial assistance and settlement of farmers on state land*

- Include HIV/AIDS awareness messages with loan materials.

(d) *Occupational health and safety strategies*

1. Identify agricultural enterprises, geographic areas and occupations with high levels of vulnerability to HIV infection and AIDS death, and liaise with appropriate Government Departments and NGOs to undertake prevention programmes.

2. Develop, with stakeholders, policies for farm worker illness benefits.

3. Review the tasks and beneficiaries of extension workers.

4. Train frontline agricultural extension workers on HIV/AIDS prevention and referral to treatment and care.

(e) *Rights of farmers, agricultural workers and rural dwellers*

1. Develop policies and monitoring systems to ensure support for destitute rural orphans, widows and older persons.

2. Assess policies and legislation to ensure that there exists adequate support for gender equality and protection of the occupancy and inheritance rights of widows and orphaned children.

(f) *Other projects, schemes and services*

1. Include HIV in environmental impact assessment and include HIV prevention in the planning stage of all agricultural and rural development projects.

2. Advocate for the inclusion of HIV/AIDS-related prevention activities in training and in the job descriptions of agricultural extension officers.

3. Include health measures in tender documents.

(g) *Agricultural training*

*   Include HIV/AIDS issues in the curriculum of agricultural training colleges.

Actions common to all ministries

This checklist can help assess how effectively each ministry has responded to HIV/AIDS – and what action still needs to be taken. By determining what initiatives have not been made, and which ones need clarification, this checklist can assist any ministry in gauging its preparedness for the HIV/ AIDS epidemic

Section

III

Action	Yes	No	Action in Progress	Action being planned	Unsure

(A) HIV/AIDS Impact Assessment

Information management: Is information about HIV/AIDS being collected, analysed, stored and spread?

Assessment of target groups: Has there been any assessment of the present impact of HIV/AIDS on Ministry target groups? Is this information up-to-date?

Assessment of future impact on target groups: Has there been any assessment on the likely future impact of HIV/AIDS on Ministry target groups?

Assessment of staff: Has there been an analysis of how HIV/AIDS will impact the Ministry in terms of direct/indirect costs due to illness and loss of staff?

Assessment of operations: Has there been an analysis of how HIV/AIDS will impact Ministry operations, including policies and programmes, in terms of direct/indirect costs?

(B) Workplace Programmes on HIV/AIDS Awareness

Programme implementation: Are programmes currently in place to raise awareness of HIV/AIDS among staff members?

Provincial staff outreach: Are programmes currently in place to raise awareness of HIV/AIDS specifically among provincial-/State-level staff members?

Action	Yes	No	Action in Progress	Action being planned	Unsure

Staff working conditions: Are assessments of, and changes to, working conditions of staff exposed to high-risk situations that may render them vulnerable to HIV infection (e.g., lengthy trips away from spouses and partners)?

Access Do staff members have access to condoms?

Participation: Are staff members of all positions and departments included in the development and implementation of HIV/AIDS prevention, care and support programmes?

Appropriate materials: Have suitable HIV/AIDS educational materials been developed, or made available by outside service providers, to include in workplace HIV/AIDS programmes?

Programme trainers: Have knowledgeable and experienced trainers been located to administer workplace programmes on HIV/AIDS?

(c) **Workplace Programmes for staff members living with HIV/AIDS or affected by it**

Eliminating discrimination: Are programmes currently in place to eliminate, among staff members, stigmatization and discrimination of people living with HIV/AIDS or affected by it?

Access to counselling: Do staff members living with or affected by HIV/AIDS have access to counselling services?

Care and support: Does the Ministry have any other specific care and support programmes for staff members living with or affected by HIV/AIDS?

Action	Yes	No	Action in Progress	Action being planned	Unsure

(D) Human Resource Policies and Procedures

Social security: Are there alternative social security options (e.g., health-care scheme, and welfare fund) for staff members living with HIV/AIDS?

Terms of leave: Have the terms for sick and unofficial leave been revised to take into account the needs of staff members living with HIV/AIDS?

Care during travel: Are there provisions for additional travel costs where staff members living with HIV/AIDS need assistance during travel on duty?

(E) HIV/AIDS Focal Point Team

Focal points: Has a team of departmental focal points on HIV/AIDS been established?

Statement, guidelines, and action plans: Has a Ministry mission statement, guidelines and actions plans on HIV/AIDS been developed?

Assessment of staff awareness: Has there been an assessment on the levels of staff awareness on HIV/AIDS issues?

(F) HIV/AIDS Task Force

Task force: Has an HIV/AIDS Task Force been established for the Ministry?

Intra-Ministry action: Are existing mechanisms for HIV/AIDS intra-Ministry action in place?

Referral network: Has a referral network for care and support services for staff members been developed?

Action	Yes	No	Action in Progress	Action being planned	Unsure
Representation: Is there Ministry representation in the National AIDS Council/Committee?					
Outside partners: Are any partners outside government – such as UN agencies and NGOs – involved in the Ministry's response to HIV/AIDS?					

(G) Ministry Good Practices

Has your Ministry researched and explored options for adapting relevant good practices from other countries?					

(H) Budget for HIV/AIDS Costs and Responses

Involvement: Is your Ministry actively involved in the design and conduct of research on HIV/AIDS?					
Follow-up: Are there mechanisms in place to follow up Ministry HIV/AIDS initiatives?					
Indicator development: Have indicators been established for measuring the progress of Ministry initiatives?					

(I) Ministry Ownership

Involvement: Is your Ministry actively involved in the design and conduct of research on HIV/AIDS?					
Costs: Is there a budget allocated to cover direct and indirect costs of HIV/AIDS on staff at all levels and in all departments?					
Responses: Is there a budget allocated to cover immediate and effective responses to HIV/AIDS, to be undertaken by the Ministry?					

Impact of HIV/AIDS within a ministry

Identifying the internal impact of HIV/AIDS within a ministry involves understanding the extent and consequences of infection among its employees.

While HIV/AIDS may severely compromise the ability of any organization to deliver, the effects may be particularly pronounced in Government, if it lacks the flexibility to respond to new pressures. The impact of employee infections would be particularly severe for ministries in the social sector, such as the Ministry of Education or of Health because of the multiplier effect of personnel infections. For example, for every teacher infected, the education of some 20 to 50 learners would be affected. The loss of key personnel in any ministry would adversely affect the functioning of that ministry, with a ripple effect in wider society.

Experience and research show that a ministry's vulnerability to employee infection depends on several key factors such as the following:

- Number of employees living with HIV/AIDS;
- Absenteeism and productivity;
- Recruitment and training;
- Morale;
- Benefits;
- Gender equality;
- Capacity to respond.

Some of these areas of vulnerability may be the ultimate responsibility of a central body, such as the Ministry of Public Service Administration, and individual sectors should liaise with that Ministry. The type of assessment needed depends on the purpose for which the data are to be used.

Consider the following questions to help identify where your ministry may be vulnerable to the impact of employee infection. Review each area of action and consider which may be relevant to your ministry.

1. Number of employees living with HIV/AIDS

The scale of the epidemic would result in considerable human suffering for employees living with HIV/AIDS. In addition, the ability of some ministries to fulfill their functions would be severely impacted.

Estimates of the size and spread of the epidemic are available from the Ministry of Health in most countries. It may be possible to use these estimates to develop a rough idea of how many ministry employees are currently HIV-positive. You may need to obtain special projections of the expected scale of the epidemic in the future: a growing number of people with HIV infections and AIDS can be expected in many countries.

You may also expect that some categories of staff would be disproportionately affected. These would include younger people, those who are mobile, such as migrants, and those who live in conditions of social instability. Evidence suggests that skilled and affluent people, mainly men, may have more opportunities for high-risk behaviour, including unprotected sex.

- What is the current level of infection?

- How many new infections are expected each year?

- What are future levels of infection, AIDS-related illness and death likely to be?

- Which categories of employees may be exposed to particularly high-risk situations?

2. Issues and action points

(a) *Absenteeism and productivity*

(i) *Issues*

Absenteeism due to illness, compassionate leave and funerals can impose large costs or inefficiencies on an organization. HIV/AIDS among different categories of personnel may affect a ministry in different ways. There may be people in key positions in the ministry who would be difficult to replace in the event of illness or absenteeism. There may be key work processes that are particularly vulnerable to unanticipated low productivity or absence of personnel.

- Which work processes or occupations are particularly vulnerable to stoppages, absenteeism and difficulties in replacing employees?
- Are there effective systems to monitor absenteeism and associated impact?
- What are the kinds and levels of costs or inefficiencies associated with absenteeism?
- Would estimation of future costs of absenteeism be useful?
- Do attitudes and support mechanisms foster early disclosure of HIV status to allow forward planning?

(ii) *Action points*

- Consider appropriateness of adapting and reorganizing work.
- Develop systems to incorporate HIV/AIDS impact on human resource planning.
- Consider strategies, such as multi-skilling, creating reserve pools of labour and overtime arrangements.

- Create an enabling environment that would facilitate early disclosure of HIV-positive status to allow forward planning and succession management.

- Streamline recruitment and appointment processes to be more efficient and effective, if feasible;

- Liaise with other appropriate ministries to achieve this.

- Cooperate with the counterpart ministry in neighbouring countries, to share sector-specific lessons.

(b) Recruitment and training

(i) Issues

HIV/AIDS within a ministry, as well as in wider society, may substantially deplete the skills-base through illness and death among trained personnel.

- What are the levels and trends in staff turnover?

- What are recruitment and training costs, and how significant may they become?

- Are training and recruitment efficiently designed to deal with pressures created by HIV/AIDS?

- Are systems in place for planning and monitoring around on-going skills requirements?

- Can recruitment and appointment processes be streamlined to ensure timely replacement of ill workers?

- Which work processes within the ministry are most vulnerable to AIDS impacts? What are potential skills shortages, where replacement staff may be hard to come by?

(ii) Action points

- Include HIV/AIDS prevention as a part of all training initiatives.
- Include training on HIV/AIDS impact management where appropriate.
- Emphasize training that enables rapid payback of investment, such as in-service training and short-course programmes.
- Mobilize external training institutions to include HIV/AIDS prevention in training courses and to consider, in course design and number of student enrolments, HIV/AIDS impact.

(c) Morale

(i) Issues

Increased illness and death among family, friends and colleagues may adversely affect employee morale.

- What impact of HIV/AIDS on staff, co-workers and their families may affect morale and productivity?

(ii) Action points

- Develop systems to provide support in the workplace for those living with and affected by HIV/AIDS.

(d) Benefits

(i) Issues

Employee benefits that are likely to be affected by HIV/AIDS include medical insurance, sick and compassionate leave, loans, retirement, coverage of disability, as well as death and funeral expenses. For assessment of HIV/AIDS impact on certain benefits, e.g., pensions, expert opinion may be required.

- What is the expected impact of HIV/AIDS on future claim levels and costs for:

  - Medical insurance?
  - Sick leave?
  - Compassionate leave?
  - Death and disability cover?
  - Funeral benefits?

- Is there any evidence of increased claims on benefits as yet?

- Are there effective systems to monitor impact on employee benefits?

- Have all options for restructuring benefits to make them sustainable and meet employee needs been considered?

Note: Collecting impact information on absenteeism, and impact on benefits, may require the establishment of management information systems. What is needed is a way to track impact over time.

(ii) Action points

- Include personal financial planning and other planning issues in HIV education programmes.

- Revise employment frameworks to ensure that benefits are sustainable and equitable and meet the needs of employees and their dependents.

- Develop health-care strategies to prolong productivity and quality of life.

- Encourage medical schemes to develop cost-effective treatment protocols and policies.

- Establish criteria for beneficiary eligibility.

(e) Gender

(i) Issues

HIV/AIDS tends to affect women disproportionately because of biological susceptibility and because women tend to be disempowered in sexual relations, as well as socially and economically.

- What factors affect women staff members' ability to protect themselves from HIV infection?
- What factors affect women's and men's ability to deal with their own illness or HIV/AIDS among household members?
- Are assessments and intervention strategies sensitive to the different needs and responses of men and women?

(ii) Action points

- Ensure that HIV/AIDS prevention programmes address the need for women's equality to negotiate safer sex.
- Educate all levels of staff on gender sensitivity issues.
- Ensure that no form of sexual harassment is tolerated in the workplace.
- Cooperate with other programmes that offer reproductive health education and services.

(f) Capacity to respond

(i) Issues

A ministry's capacity to respond to employee infections is critical to reduce the impact of these infections. Capacity issues include appropriate dissemination of HIV/AIDS workplace policies, support

services or employee assistance programmes, allocation of personnel and resources for HIV/AIDS issues and HIV/AIDS impact monitoring systems.

- Is there an HIV/AIDS policy in place?
- Is the current HIV/AIDS policy adequate to protect employees and the employer from unnecessary costs?
- Do line and other managers feel confident in applying the policy and managing HIV issues in the workplace?
- What services are available to support affected or infected employees?
- Have committees, teams and/or persons responsible for HIV/AIDS issues been identified?
- Do they have adequate expertise and resources?
- Are there effective systems to monitor impact on employee benefits, absenteeism, and other costs?

(ii) Action points

- Develop or review the ministry's HIV/AIDS workplace policy to ensure that it is in line with the HIV/AIDS policy in other government bodies, adheres to acceptable ethical standards, preferably according to international guidelines.
- Conduct information campaigns for human resource and line managers on HIV/AIDS policy and other HIV/AIDS issues.
- Establish management information systems to track the impact of AIDS on at least the following:
    - Absenteeism;
    - Sick leave;
    - Death in service;
    - Benefits.

- Identify persons responsible for HIV/AIDS responses within the ministry and ensure that they have sufficient authority and capacity to act.

- Set up a dedicated HIV/AIDS committee to coordinate HIV/AIDS activities.

- Include HIV/AIDS as an on-going agenda item in relevant management meetings.

- Network with persons/task teams in other government ministries.

- Insert HIV/AIDS as a line item in budgets, as appropriate.

- Make confidential contact points with management available for employees.

- Ensure contact details for counselling and support services are available and that these services are familiar with the ministry's approach to HIV/AIDS.

3. *Responses in areas of internal impact*

Review each of the following areas of action and consider which may be relevant to your ministry. Ensure the involvement of all relevant stakeholders in planning action responses.

It would also be important to develop and disseminate an HIV/AIDS policy, as this would help to guide response planning and implementation.

4. *Prevention of new infections*

- Implement effective workplace HIV prevention programmes that include:

- Treatment of sexually transmitted infections;
- Condom distribution;
- Provision of education and information.

- Evaluate existing prevention programmes to identify any deficiencies.

- Strengthen workplace HIV prevention programmes, if needed.

- Address situations that put employees at high risk of infection, e.g., migrant labour, long periods away from home.

- Ensure prevention programmes target key workers and workers at high risk.

HIV/AIDS IN ASIA AND THE PACIFIC

BYTES THAT MATTER

FAQs
Facts & Myths
Pathfinder
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